HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
AUGUST 24, 2016
APPLICATION SUMMARY

NAME OF PROJECT:	East Tennessee Healthcare Holdings, Inc.
PROJECT NUMBER:	CN1605-021
ADDRESS:	203 Gray Commons Circle, Suite 110 Johnson City, (Washington County), Tennessee 37615
LEGAL OWNER:	East Tennessee Healthcare Holdings, Inc. 400 N. State of Franklin Road Johnson City (Washington County), TN 37604-6035
OPERATING ENTITY:	Mountain States Health Alliance 303 Med Tech Parkway, Suite #330 Johnson City, TN 37604
CONTACT PERSON:	Allison Rogers, VP of Strategic Planning (423) 302-3378
DATE FILED:	May 17, 2016
PROJECT COST:	$1,747,777.00
FINANCING:	Cash Reserves
PURPOSE OF REVIEW:	Establishment of a nonresidential substitution-based treatment center for opiate addiction and the initiation of opiate addiction treatment

DESCRIPTION:

East Tennessee Healthcare Holdings, Inc. (ETHHI) is seeking approval to establish a nonresidential substitution-based treatment center that provides opiate addiction treatment (referred to as OTP for opiate treatment program throughout the remainder of the report). Mountain States Health Alliance (MSHA) and East Tennessee State University (ETSU) have formed the not-for-profit Corporation ETHHI to be licensed by the Department of Mental Health and Substance Abuse Services (TDMHSAS). The OTP will provide individual counseling and group therapy and will be limited to the provision of methadone as a medication assisted treatment option to prevent symptoms of withdrawal in

Year One and Year Two of the project, and will add the medication suboxone in Year Three. The Tennessee declared primary service area (PSA) includes Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi and Washington Counties; and the Virginia counties of Wise, Scott, Washington, and the city of Bristol City, Virginia. The projected payor mix will consist of Private/Self-pay only. If approved, the applicant plans to discuss with TennCare the possibility of a direct contract for buprenorphine (suboxone), and broader benefit age span for methadone and related transportation services. The applicant will also discuss with Medicare the possibility of future Medicare participation.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW:
NON-RESIDENTIAL METHADONE TREATMENT FACILITES (NRMTF)

A non-residential narcotic treatment facility should provide adequate medical, counseling, vocational, educational, mental health assessment, and social services to clients enrolled in the opioid treatment program with the goal of the individual becoming free of opioid dependency.

The applicant reports that clients will receive the following services as part of an individualized treatment plan in the proposed OTP: medical, counseling (individual and group), vocational, educational, mental health assessments, and social services. Clients will be supervised by a physician board eligible in psychiatry and 2 years of documented experience in the treatment of persons who are addicted to alcohol or drugs: or certified as an Addiction Medicine Specialist by the American Society of Addiction Medicine (ASAM), or Board Certified as an Addiction Medicine Specialist. The applicant projects 1,050 clients in Year 2 while employing one Licensed Clinical Social Worker (LCSW) and 5 unlicensed therapists.

The TDMHSAS Report (page 2) indicates the applicant describes the ETHHI strategy as combining clinically valid treatment options with comprehensive services including counseling and support services (e.g. facilitating employment and housing). The applicant indicates that the Center will also provide clinical training, community education and outreach, and practical research and evaluation funded by grants awarded to ETSU. The applicant intends to partner with Frontier Health for therapy and recovery services to augment the opioid replacement services provided by the OTP, and the applicant intends to contract directly with Frontier for 5.0 FTEs of licensed and unlicensed therapists to provide on-site counseling and a smooth referral process for additional Frontier co-occurring services, if needed.

The TDMHSAS report does not indicate if applicant's proposed level of services is adequate to meet licensure standards. It is unclear if the

applicant's medical director's qualifications (page 54) will meet TDMHSAS rules or if the counselor to patient ratio in Year 2 is adequate. It is unknown whether this criterion has been met.

Need

The need for non-residential narcotic treatment facilities should be based on information prepared by the applicant for a certificate of need, which acknowledges the importance of considering the demand for services along with need and addressing and analyzing service problems as well.

The assessment should cover the proposed service area and include the utilization of existing service providers, scope of services provided, patient origin, and patient mix.

The assessment should consider that the users of opiate drugs are the clients at non-residential narcotic treatment facilities, and because of the illegal nature of opiate drug use, data will be based on estimates, actual counts, arrests for drug use, and hospital admittance for drug abuse.

The assessment should also include:

1. **A description of the geographic area to be served by the program;**

   The applicant proposes to serve eligible individuals residing in an eight County service area, which includes Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington Counties.

   It appears that this criterion has been met.

2. **Population of area to be served;**

   The population of the proposed service area in 2016 is 643,005.

   The estimated number of persons, in the described area, addicted to heroin or other opioid drugs and an explanation of the basis of the estimate;

   The applicant estimates there are 29,000 individuals in need of early intervention or treatment of addiction for prescription opioids in the proposed eight county service area. The applicant calculated the estimates from a 2014 TDMHSAS report titled "Prescription for Success: Statewide

Strategies to Prevent and Treat the Prescription Drug Epidemic in Tennessee".

The TDMHSAS staff report indicates the applicant's estimate of the total patient pool in the Tennessee counties based on a rate of 165 patients per 100,000 residents in Year One of operation (2018) is 879 and in year 2 (2019) is 882. In Supplemental #1, the applicant projects there will be 2,411 in the 8 county service area addicted to heroin in 2020. The TDMHSAS staff report indicates these appear to be reasonable estimates based on known rates of abuse and typical proportion of abusers appropriate for medication-assisted treatment.

Please refer to page 4 of the TDMHSAS report.

It appears that this criterion has been met.

3. **The estimated number of persons, in the described area, addicted to heroin or other opioid drugs presently under treatment in methadone and other treatment programs;**

The TDMHSAS report notes there are currently 29 residents from the 8 County proposed service area enrolled in services at two Knoxville, TN OTP providers and one Chattanooga OTP provider.

Using 2012 OTP data from TDMHSAS the applicant calculated a statewide use rate of 145.0 per 100,000 population. The applicant applied the use rate to the 2016 8 county service area population of 643,005 and concluded there are at least 950 current OTP patients. The applicant pointed out the 950 patient estimate is conservative and is based on 4 year old use rate data and does not account for any significant growth of opioid abuse since 2012.

It appears that this criterion has been met.

4. **Projected rate of intake and factors controlling intake;**

The applicant projects the rate of intake will be 60 clients per in Year One.

It appears that this criterion has been met.

5. **Compare estimated need to existing capacity.**

The applicant estimates there are 29,000 from the proposed service area defined as potentially in need of treatment or early intervention for prescription drug abuse. There are no existing OTPs in the service area.

It appears that this criterion has been met.

Also, consideration should be given to the reality that existing facilities can expand or reduce their capacity to maintain or treat clients without large changes in overhead.

There are no existing OTPs in the proposed 8 county service area.

It appears that this criterion is not applicable.

Service Area

The geographic service area should be reasonable and based on an optimal balance between population density and service proximity.

The applicant provides a chart on page 30 of Driving Distances from the proposed OTP clinic location to each of the counties in the proposed 8 county service area in comparison to the closest existing OTP clinics. If approved, an OTP in Washington County will shorten the round trip to the closest existing OTP in 7 out of 8 counties in the proposed service area.

It appears that this criterion has been met.

The relationship of the socio-demographics of the service area and the projected population to receive services should be considered. The proposal's sensitivity to and the responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, and low-income groups.

Charity care equals approximately 5.0% of total gross revenue in Year One and Year Two totaling $78,000 and $181,125, respectively. Charity Care calculates to 32.50 clients per year in Year One. The applicant plans to provide Neonatal Abstinence Syndrome services which include the treatment of mother, infant, and preventing a second pregnancy. The proposed service area represents a racial composition of 92% Caucasian. The applicant did not identify any special needs of ethnic minorities in the service area.

It appears that this criterion has been met.

Relationship to Existing Applicable Plans

The proposals' estimate of the number of clients to be treated, anticipated revenue from the proposed project, and the program funding source with

description of the organizational structure of the program delineating the person(s) responsible for the program, should be considered.

The applicant proposes to provide services to 650 clients in 2018 generating gross operating revenues of $1,560,000 in Year One. Treatment is self-funded by the patient. The applicant notes the program is in the developmental phase and the organizational structure is still being determined as is the person responsible for the program.

It appears that this criterion has been partially met.

The proposals' relationship to policy as formulated in local and national plans, including need methodologies, should be considered.

There appears to be no local or national plans that include need methodologies.

It appears that this criterion is not applicable.

The proposals' relationship to underserved geographic areas and underserved population groups, as identified in local plans and other documents, should be a significant consideration.

There are no identified local plans or and other documents that specifically address nonresidential substitution-based opioid treatment programs.

It appears this criterion is not applicable.

The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

The applicant plans to utilize self-pay programs and does not plan to participate in State and Federal programs such as TennCare or Medicare.

It appears that this criterion is not applicable

The degree of projected financial participation in the Medicare and TennCare programs should be considered.

Initially, the applicant plans to utilize self-pay programs and does not plan to participate in State and Federal programs such as TennCare or Medicare. If approved, the applicant plans to discuss with TennCare the possibility of a direct contract for buprenorphine (suboxone), and broader benefit age span for

methadone and related transportation services. The applicant will also discuss with Medicare the possibility of future Medicare participation.

It appears that this criterion is not applicable

Note to Agency members: It is unclear what type of Medicare participation the applicant will discuss with Medicare. The medication Methadone is not covered under the Medicare basic Part D benefit for the treatment of opioid dependence. Methadone is not a Part D drug when used for the treatment of opioid dependence because it cannot be dispensed for this purpose upon a prescription at a retail pharmacy.
Source: https://www.cms.gov/outreach-and-education/outreach/partnerships/downloads/determine.pdf

SUMMARY:

East Tennessee Healthcare Holdings, Inc. proposes to establish an OTP located at 203 Gray Commons Circle, Suite 110, Johnson City (Washington County), Tennessee. The applicant describes the proposed project as a unique opportunity to develop a comprehensive, innovative, holistic model of care by bringing together the local academic and research resources of ETSU; coupled with the medical care expertise and capital resources of MSHA. The applicant will also contract with Frontier Health, based in Gray, Tennessee, to provide therapeutic and recovery based services. In 2004 Frontier Health began an opioid replacement program in Virginia limited to the provision of suboxone as a medication assisted treatment option with a goal of medication free recovery.

The proposed hours of operation are Mon-Fri, 5:00 A.M.-3:00 P.M. and Saturday/Sunday between 6:00 A.M. to 9:00 A.M.

Ownership

- East Tennessee Healthcare Holdings, Inc. (ETHHI) is an active nonprofit corporation formed on May 10, 2016 registered with the Tennessee Secretary of State.
- ETHHI is 50% owned by Mountain States Health Alliance and 50% owned by East Tennessee State University Research Foundation.
- East Tennessee State University Research Foundation is operated exclusively for purposes related to research, public service, and instructional functions of East Tennessee State University (ETSU).
- Mountain State Health Alliance (MSHA) operates 13 hospitals located in Tennessee, Virginia, Kentucky, and North Carolina.

- MSHA owns Woodridge Psychiatric Hospital which is the only adult, pediatric, geriatric acute care hospital in the region that treats addiction and dual diagnosis patients.
- Mountain States Health Alliance will manage the proposed facility. A copy of the draft management agreement is located in Attachment A.5.
- Please refer to Attachment A.4 for a list ownership interests of Mountain States Health Alliance.

Facility Information

- The applicant will locate in 7,851 SF of an existing single story 11,761 SF facility located on a 4.360 acre lot of a 36.2 acre site with a parking lot consisting of 79 parking spaces.
- The applicant will renovate the 7,851 SF of space redesigned to meet the needs of the OTP clinic at a cost of $196,275 or $25.00 per SF.
- The remaining 3,910 SF of the 11,761 SF facility is home to one MHSA related office for physician recruitment staff and one office for Synergy Laboratories staff.
- Mountain States Properties, Inc. a wholly owned, second tier, subsidiary of Mountain States Health Alliance will lease the property to East Tennessee Healthcare Holdings, Inc. through a signed 10 year Option to Lease agreement.
- The proposed site was previously leased to MSHA's medical management group for a family practice and an urgent care center.

The proposed 7,851 SF facility will contain the following areas:

- A group counseling room and 13 counseling offices; a break room; a laboratory; pharmaceutical storage; and chart room.
- Patient reception/waiting area, restrooms for staff, clients and drug screening tests.
- Office space for Nursing Staff, Program Director, Clinic Director and Medical Director.
- A floor plan drawing for the facility is located in Attachment B.IV.—Floor Plan.

There are currently no other licensed OTP facilities in the proposed service area. If approved, East Tennessee Healthcare Holdings. Inc. will be the 13th OTP in the state (note: a map of all licensed and proposed OTPs is provided in Attachment C, Need (2)). The closest treatment facilities in the state are located in Knoxville (Knox County), TN and are owned by Behavioral Health Group (BHG). BHG is based in Dallas, Texas and currently owns a majority of the existing OTP clinics (nine of the twelve) in Tennessee. BHG owns clinics in Knoxville (2), Nashville (1), Memphis (3), Jackson (1), Paris (1), and Columbia (1).

The applicant provides a TDMHSAS table on page 41 of the application noting there were 29 residents in 2014 from the 8 County proposed service area enrolled in OTP services at Knoxville (2) and Chattanooga (1), TN providers. The following table displays the 2014 service area out-migration for the eight- county service area to Tennessee OTPs and their overall utilization:

2014 TDMHSAS Methadone Registry and Proposed Service Area Out-Migration to existing Tennessee OTP providers.

	Treatment Facility			
Utilization	**Hamilton Co.- Volunteer TX Ctr.**	**Knox DRD Knoxville- (Bernard)**	**Knox DRD Knoxville,- (Citico)**	**Total**
2012 Total Patients	726	520	524	**1,770**
2013 Total Patients	1,002	639	651	**2,292**
2014 Total Patients	1,749	923	964	**3,636**
% Change 12'-14'	+140%	+77.5%	+84%	**+105%**
Patients from the 8 County TN proposed Service Area				
2012	9	10	1	**20**
2013	9	10	10	**29**
2014	9	10	10	**29**

Source: CN1605-021, TDMHSAS, May 12, 2016

- The existing three OTP providers located in the East Tennessee grand region experienced an 105% increase of patients from 1,770 in 2012 to 3,636 in 2014.

The closest Tennessee OTP is located in Knoxville (Knox County), Tennessee which is located over 100 miles away or approximately 1 hour and 37 minute drive time from the proposed clinic site. The closest out of state OTP is located in Weaverville, NC with a traveling distance of 45.6 miles/45 minutes for residents of Johnson City, TN. The following chart reflects the closest OTP to each of the 8 Counties in the proposed service area in comparison to the proposed ETHHI (applicant) planned to be located in Johnson City (Washington County), TN.

Analysis of Driving Distances from Proposed Clinic Location
In Comparison to the Closest Existing OTP Clinics by County

OTP Provider	Carter	Greene	Hancock	Hawkins	Johnson	Sullivan	Unicoi	Washington
Distance/Time to proposed ETHHI Treatment Center by County								
Proposed ETHHI, Johnson City, TN	20.2 mi./29 min.	28.8 mi./44 min.	64.1 mi./83 min.	41.4 mi/48 min.	55.0 mi/71 min.	15.6 mi/19 min.	25.6 mi/28 min	11.2 mi/15 min.
Distance/Time to Closest existing OTP to each County in the proposed service area								
Crossroads of Weaverville, Weaverville, NC	52.3 mi./ 56 min.	N/A	N/A	N/A	N/A	69.3 mi/67 min	31.2 mi./32 min.	45.6 mi/45.6 min
DRD Knoxville Medical Clinic	N/A	70.6 mi/66 min	69.1 mi/85 min	73.4 mi/73 min.	N/A	N/A	N/A	N/A
Galax Treatment Ctr. Cedar Bluff, Virginia	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Stepping Stones, Boone, NC	N/A	N/A	N/A	N/A	26.6 mi./35 min.	N/A	N/A	N/A
***If Crossroads Treatment Center is approved, the difference in miles and daily round trip savings are listed below**								
Difference in nearest OTP miles/time	-32.1 mi./27 min.	-41.8 mi./22min	-5.0 mi./ -2.0 min.	-32 mi./25min	+28.40 mi/ +36 min.	-53.70 mi./ -50.3 min.	-5.60 mi./ - 4min.	-34.4 mi./ -30.60 min.
Daily Round Trip Savings	**-64.2 mi./ 54 min..**	**-83.6 mi/ - 44 min.**	**-10 mi./ - 4 min.**	**-64 mi / - 50 min.**	**+38 mi./ +1 hr.**	**-107.40 mi./1 hr. 41 min.**	**-11.20 mi./ -8 min.**	**-68.80 mi./ -1 hr. 1 min.**

Source: CN1605-021
**A negative difference in miles/time represents a saving in daily commuting; a positive difference represents additional miles/time.*

- If approved, an OTP in Washington County will shorten the round trip to the closest existing OTP in 7 out of 8 counties in the proposed service area.
- The ranges in shorter round trips to a new Washington County OTP are from 11.2 miles (15 minutes) from Johnson City (Washington County) to 64.1 miles (1 hr. 23 minutes) from Sneedville (Hancock County).
- A new OTP in Washington County will not decrease the daily round trip to an OTP for residents in Johnson County.
- A complete chart of driving distances from each county in the proposed service area to the nearest 6 OTPs is located on page 30 of the original application.
- State and federal OTP regulations require new patients to make daily commutes (6 or 7 days) for up to 3 months of treatment.

Project Need

The applicant states the proposed project is needed for the following reasons:

- Need is established by the lack of any existing non-residential OTP clinics in the proposed Tennessee 8 county service area.
- Patients who reside in the proposed service area must drive anywhere from 26 to 78 miles one way to obtain OTP treatment.
- An estimated 29,000 people residing in the proposed service area struggle with addiction to heroin, morphine and prescription opioids.

Service Area Demographics

The primary service area (PSA) includes Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi and Washington counties; and the counties of Lee, VA, Scott, VA, Washington, VA, and the city of Bristol City, Virginia.

The total population of the Tennessee service area is estimated at 643,005 residents in CY 2016 increasing by approximately 1.9% to 655,045 residents in CY 2020.

- The overall Tennessee statewide population is projected to grow by 4.3% from 2016 to 2020.
- The number of residents enrolled in TennCare ranges by county from 18.9% (Washington County) to 35% (Hancock County) of the total service area population compared to 22.5% statewide.
- The overall Virginia statewide population is projected to grow by 4% from 2016-2020.

Source: The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics; CN1605-021.

Historical Utilization

The following table represents the 8 county out-migration of Tennessee OTP clients to North Carolina and the 2014 percentage share of business from Tennessee residents for each OTP.

***Service Area OTP Historical Utilization and Share**

OTP	Distance from applicant	2012 Total Patients	2013 Total Clients	2014 Total Patients	'12-'14 % Change	Clients from the proposed 8 county service area			'12-'14 % Change	2014 Service Area Clients as a % of Total
						2012	2013	2014		
Crossroads of Weaverville, NC	51.8 miles	441	463	495	+12.2%	227	241	260	+14.5%	52.5%
Crossroads of Asheville, NC	59.3 miles	635	645	657	+3.4%	33	34	35	+6.0%	5.3%

Source: Crossroad Treatment Center, CN1511-048

**Public information is not available from the following OTPS: BHG Asheville Treatment Center, Asheville, NC; Mountain Area Recovery Center, Inc., Asheville, NC; Mountain Health Solutions, Asheville, NC; Western Carolina Treatment Center, Asheville, NC; and New River Comprehensive Treatment Center, Galax, VA*

- Crossroads of Weaverville, NC percentage of clients from the proposed Tennessee service area totaled 52.5% of their overall business, or 260 of 495 clients in 2014.

Public OTP utilization data from states that border Tennessee are not available. The following table indicates the current number of clients as of November 2015 from the proposed 8 county service area, by County, that are served by out of state bordering OTP providers. The following table is an excerpt from the application, Crossroads Treatment Centers, CN1511-048W.

OTP	Carter	Greene	Hancock	Hawkins	Johnson	Sullivan	Unicoi	Washington	Total
Crossroads of Weaverville, NC	64	14	7	19	1	74	9	89	*277
Crossroads of Asheville, NC	3	5	1	11	0	9	0	7	*36

Source: CN1511-048W

**Public information is not available from the following OTPS: BHG Asheville Treatment Center, Asheville, NC; Mountain Area Recovery Center, Inc., Asheville, NC; Mountain Health Solutions, Asheville, NC; Western Carolina Treatment Center, Asheville, NC; and New River Comprehensive Treatment Center, Galax, VA*

- Crossroads of Weaverville, NC served the highest number of clients with 277 clients in November 2015, ranging from 1 patient residing in Johnson County to 89 residing in Washington County.
- Crossroads of Asheville, NC served 36 clients in November 2015 ranging from 0 to 11 from each county in the proposed 8 county service area.

Note to Agency members: The application, Crossroads Treatment Centers, CN1511-048W, was filed in November 2015, and withdrawn on April 11, 2016. Crossroads Treatment Centers, CN1511-048W, proposed Tennessee 8 county service area mirrored that of the applicant.

Applicant Projected Utilization

The applicant proposes to serve 650 clients in Year 1 (2018) and 1,050 clients in Year 2 (2019). The following chart indicating the patient origin by county/state in Year One and Year Two of the proposed project.

	Carter	Greene	Hancock	Hawkins	Johnson	Sullivan	Unicoi	Washington	Virginia	Total
Clients Year 1	59	73	7	59	19	160	19	138	116	650
Clients Year 2	94	119	11	96	31	257	31	224	187	1,050

Source: CN1605-021 Supplemental #2

The applicant plans to add buprenorphine as a treatment option in the third year of operation. The following chart displays Year Three Projections.

	# Methadone Patients	# Buprenorphine Patients	Total
Year 3	1,060	70	1,130

Source: CN0605-021 Supplemental #1

The applicant indicates there are currently 117 unique buprenorphine certified providers in the proposed 8 county service area.

Note to Agency Members: The Addiction Treatment Act of 2000 allows qualifying physicians to receive a waiver from the special registration requirements in the Controlled Substances Act for the provision of medication-assisted opioid therapy. This waiver allows qualifying physicians to practice medication-assisted opioid addiction therapy with Schedule III, IV, or V narcotic medications specifically approved by the Food and Drug Administration (FDA). On October 8, 2002 Subutex® (buprenorphine hydrochloride) and Suboxone® tablets (buprenorphine hydrochloride and naloxone hydrochloride) received FDA approval for the treatment of opioid addiction. The physician has the capacity to refer addiction therapy clients for appropriate counseling and other non-pharmacologic therapies, and that the physician will not have more than 30 clients on addiction therapy at any one time for the first year. (Note: the number of a physician's practice locations does not affect the 30-patient limit. One year after the date on which the physician submitted the initial notification, the physician will be able to submit a second notification stating the need and intent to treat up to 100 clients.) Source: http://buprenorphine.samhsa.gov/waiver_qualifications.html

Update: A new rule finalized on July 6, 2016 by the Substance Abuse and Mental Health Services Administration (SAMHSA) allows practitioners who have had a waiver to prescribe buprenorphine for up to 100 patients for a year or more, to now obtain a waiver to treat up to 275 patients. Practitioners are eligible to obtain the waiver if they have additional credentialing in addiction medicine or

addiction psychiatry from a specialty medical board and/or professional society, or practice in a qualified setting as described in the rule. Source: http://www.hhs.gov/about/news/2016/07/06/hhs-announces-new-actions-combat-opioid-epidemic.html

The physicians listed by SAMSHA may not be accepting new patients. There are no public registry reporting requirements for buprenorphine providers in Tennessee that confirms capacity and reflects current caseloads, access, and any applicable waiting lists.

Project Cost

Major costs of the $1,747,777 total estimated project cost are as follows:

- Facility Lease –Cost of $1,031,595.00, or approximately 59% of total cost.
- Fixed Equipment- Cost of $251,050, or 14.4% of total cost.
- Renovation Costs plus Contingency, $242,497, or 13.9% of total cost.
- For other details on Project Cost, see the Project Cost Chart on page 44 of the application.

Historical Data Chart

- Since the applicant is proposing a new OTP, there is no historical data available.

Projected Data Chart

The applicant projects $1,560,000 in total gross revenue on 650 clients during the first year of operation and $3,622,500 on 1,050 clients in Year Two. The Projected Data Chart reflects the following:

- Net operating income less capital expenditures for the applicant will equal ($326,421) in Year One increasing to $956,425 in Year Two.
- Net operating revenue after charity care is expected to reach $3,405,150 or approximately 94% of total gross revenue in Year Two.
- Charity care at approximately 5.0% of total gross revenue in Year One and Year Two equaling to $78,000 and $181,125, respectively.
- Charity Care calculates to 32.50 clients per year in Year One.

Patient Charges

- The cost of Methadone Maintenance Treatment after initial intake is approximately $13.00 per day.
- The $13.00 cost per day is inclusive of the medication, counseling, case management/social work, and testing.

- The applicant surveyed Behavioral Health Group (that operates 10 of the 12 existing OTP clinics in Tennessee) and found routine daily charges range from $14.00 to $15.00 per day for treatment.

Payor Mix

- The applicant indicates it does not expect to receive any revenues from TennCare, Medicare, or other state or federal sources.
- The projected payor mix includes Private/Self-pay only. Charity care represents 32.50 clients in Year One of the project.

Note to Agency Members: Methadone Maintenance Treatment (MMT) is not a TennCare covered service for adults over the age of 21. MMT is a covered service for enrollees between 18 and 20 years but TennCare will not directly reimburse the facility. TennCare covers generic buprenorphine, Subutex and Suboxone for opiate addiction. To be reimbursed for medically necessary services, persons between 18 and 20 years old pay out of pocket for treatment. OTPs submit required documentation to the MCO so the patient can be reimbursed.
The medication Methadone is not covered under the Medicare basic Part D benefit for the treatment of opioid dependence.

Financing

- A May 11, 2016 letter from the Senior Vice-President/Chief Financial Officer of Mountain States Health Alliance states that the applicant anticipates funding the project from cash reserves.
- Review of Mountain States Health Alliance's Balance Sheet for the period ending June 30, 2015 revealed $328,823,000 in total current assets, total current liabilities of $235,593,000 and a current ratio of 1.40 to 1.0.
- ***Note to Agency Members: current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.***

Staffing

The applicant's proposed direct patient care staffing includes the following full time equivalent (FTE) positions.

	FTE Year One	FTE Year Two
Medical Director	1.0	1.0
On-site Prescriber	1.0	2.0
Nurses-RNs	1.0	2.0
Nurses LPN	1.0	2.0
Licensed Clinical Social Worker	1.0	1.0
Unlicensed Therapists	2.0	4.0
Clinical Pharmacist	0.3	1.0
Psychiatric Nurse Practitioner	1.0	1.0
Program Director Operations	1.0	1.0
Total	**11.5**	**15.0**

Source: CN1605-021

Licensure/Accreditation

- If approved, the OTP will be licensed by the Department of Mental Health and Substance Abuse Services.
- The applicant will seek accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF).

Notices

TCA § 68-11-1607 (c) (3) requires an applicant for a nonresidential substitution-based treatment center for opiate addiction to file notices with certain state, county, and local government officials within 10 days of filing the CON application. HSDA staff verified the applicant met all requirements of TCA § 68-11-1607 (c) (3). The applicant documented the following officials had been notified:

- State Representative James (Micah) Van Huss
- State Senator Rusty Crowe
- Washington County Mayor Dan Eldridge
- City of Johnson City Mayor Clayton Stout

Public Hearing

Tennessee Health Services and Planning Act, 68-11-1608 (b), states "upon request by interested parties or at the direction of the executive director, the staff of the agency shall conduct a fact-finding public hearing on the application in the area in which the project is to be located". A public hearing was requested for this application. The hearing was held on August 5, 2016 in the Little Theatre in Daniel Boone High School, 1440 Suncrest Drive, Gray (Washington County), Tennessee. A copy of the minutes and transcript are attached behind the application.

The applicant has submitted the required corporate and real estate lease documentation. HSDA staff reviewed these documents. A copy will be available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency office.

Should the Agency vote to approve this project, the CON would expire in **two** years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

There are no other Letters of Intent, pending applications, denied applications, or outstanding Certificates of Need for this applicant.

CERTIFICATE OF NEED INFORMATION FOR OTHER PROVIDERS IN THE SERVICE AREA:

There are no letters of intent, or pending applications, or outstanding Certificates of Need for other health care organizations in the service area proposing this type of service.

Denied Applications

Tri-Cities Holdings LLC d/b/a Trex Treatment Center, CN1303-005D, was denied at the June 26, 2013 Agency meeting. The application was for the establishment of a non-residential substitution-based treatment center for opiate addiction offering methadone and buprenorphine to treat opiate addiction preventing symptoms of withdrawal. The estimated project cost was projected to be $670,000. *Reason for Denial: The application did not meet the statutory criteria. There was not a need for this service as there were effective treatment options available for opiate addiction in the area.*

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCES ABUSE SERVICES FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, HEALTH CARE THAT MEET APPROPRIATE QUALITY STANDARDS, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME 08/01/2016

LETTER OF INTENT

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Johnson City Press (Name of Newspaper) which is a newspaper of general circulation in Washington (County), Tennessee, on or before May 12th (Month / day), 2016, (Year) for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

East Tennessee Healthcare Holdings, Inc. (Name of Applicant) _____ (Facility Type-Existing)

owned by: East Tennessee Healthcare Holdings, Inc. with an ownership type of Not-for-Profit Corporation and to be managed by: Mountain States Health Alliance intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: the establishment of a non-residential substitution-based treatment center for opiate addiction to be located at 203 Gray Commons Circle, Johnson City (Washington County), TN 37615. The estimated project cost is $1,747,777.

The anticipated date of filing the application is: May 17th, 2016

The contact person for this project is Allison Rogers (Contact Name) VP, Strategic Planning (Title)

who may be reached at: Mountain States Health Alliance (Company Name) 303 Med Tech Parkway, Suite #330 (Address)

Johnson City (City)	TN (State)	37604 (Zip Code)	423/302-3378 (Area Code / Phone Number)
Allison M. Rogers (Signature)		5/11/2016 (Date)	RogersAM@msha.com (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Original Application Copy

East TN Healthcare Holdings, Inc

CN1605-021

EAST TENNESSEE HEALTHCARE HOLDINGS, INC.

Certificate of Need Application
May 17th, 2016

Prepared for:
Tennessee Health Services and Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street Nashville, TN 37243
615.741.2364

Contact:
Allison Rogers
423.302.3378

SECTION A:

APPLICANT PROFILE

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate *"N/A"*. ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.***

For Section A, Item 1, *Facility Name* ***must be*** *applicant facility's name and address* ***must be*** *the site of the proposed project.*

For Section A, Item 3, *Attach a copy of the partnership agreement, or corporate charter* ***and*** certificate of corporate existence, if applicable, from the Tennessee Secretary of State.

For Section A, Item 4, *Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in* Tennessee Code Annotated, §68-11-1602 *in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.*

For Section A, Item 5, *For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.*

Please describe the management entity's experience in providing management services for the type of the facility, which is the same or similar to the applicant facility. Please describe the ownership structure of the management entity.

For Section A, Item 6, *For applicants or applicant's parent company/owner that currently own the building/land for the project location; attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

SUPPLEMENTAL #2
May 31, 2016
11:44 am

1. ***Name of Facility, Agency, or Institution***

East Tennessee Healthcare Holdings, Inc.
Name

203 Gray Commons Circle, Suite 110 — Washington
Street or Route — County

Johnson City — TN — 37615
City — State — Zip Code

2. ***Contact Person Available for Responses to Questions***

Allison Rogers — VP, Strategic Planning
Name — Title

Mountain States Health Alliance — RogersAM@msha.com
Company Name — Email address

303 Med Tech Parkway, Suite #330 — Johnson City — TN — 37604
Street or Route — City — State — Zip Code

Employee — 423.302.3378 — 423.302.3448
Association with Owner — Phone Number — Fax Number

3. ***Owner of the Facility, Agency or Institution***

East Tennessee Healthcare Holdings, Inc. — 423.431.6111
Name — Phone Number

400 N. State of Franklin Road — Washington
Street or Route — County

Johnson City — TN — 37604-6035
City — State — Zip Code

4. ***Type of Ownership of Control (Check One)***

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership		G. Joint Venture	
C. Limited Partnership		H. Limited Liability Company	
D. Corporation (For Profit)		I. Other (Specify)_____	
E. Corporation (Not-for-Profit)	X		

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

5. ***Name of Management/Operating Entity (If Applicable)***

Mountain States Health Alliance
Name

303 Med Tech Parkway, Suite #330 — Washington
Street or Route — County

Johnson City — TN — 37604
City — State — Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership		D.	Option to Lease	X
B.	Option to Purchase		E.	Other (Specify)	
C.	Lease of ____ Years				

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify)		I.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		J.	Outpatient Diagnostic Center	
			K.	Recuperation Center	
C.	ASTC, Single Specialty		L.	Rehabilitation Facility	
D.	Home Health Agency		M.	Residential Hospice	
E.	Hospice		N.	Non-Residential Methadone Facility	X
F.	Mental Health Hospital		O.	Birthing Center	
G.	Mental Health Residential Treatment Facility		P.	Other Outpatient Facility (Specify)	
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)		Q.	Other (Specify)	

8. **Purpose of Review *(Check) as appropriate--more than one response may apply)***

A.	New Institution	X	G.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	
B.	Replacement/Existing Facility				
C.	Modification/Existing Facility				
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify)		H.	Change of Location	
			I.	Other (Specify)	
E.	Discontinuance of OB Services				
F.	Acquisition of Equipment				

9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

		Current Beds Licensed	*CON	*Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	**0**	**0**	**0**	**0**	**0**

*CON-Beds approved but not yet in service

10. Medicare Provider Number Not applicable

Certification Type _____

11. Medicaid Provider Number Not applicable

Certification Type _____

12. If this is a new facility, will certification be sought for Medicare and/or Medicaid?

RESPONSE:

It is not the immediate intention of this project to seek Medicare and Medicaid certification but it may do so in the future.

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants? No If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.***

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

RESPONSE:
The TennCare benefit for substitution-based treatment is very limited and the financial projections do not include TennCare patients. However, the applicant intends to diligently investigate the ability to contract directly with the TennCare MCOs/BHOs for this patient population.

NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

RESPONSE:

This application proposes to establish a non-residential substitution-based treatment center for opiate addiction within Washington County, TN. Mountain States Health Alliance (MSHA) and East Tennessee State University (ETSU) have formed a not-for-profit corporation, East Tennessee Healthcare Holdings, Inc. (ETHHI) which will own and operate this proposed non-residential Opioid Treatment Program (OTP). The proposed project will be located at 203 Gray Commons Circle, Johnson City, TN 37615 and will occupy 7,851 square feet of existing space will be renovated to meet the needs of the clinic. The estimated project cost is $1,747,777. Funding for this project will be through the use of existing cash reserves of MSHA.

The project stems from the need to help the estimated 29,000 people in the service area who struggle with addiction to heroin, morphine and prescription opioids. Per research the College of Public Health at ETSU has collated, the following statistics put the magnitude of this issue in East Tennessee into perspective.

- USA is #1 in the world: USA consumes twice as many opioids per capita than the next closest nation
- Tennessee is #2 in the #1 country: Alabama is #1 by a tenth of a point; West Virginia is a distant third
- East Tennessee is #1 in the state

Sources: Paulozzi, et al (2014) Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines—United States, 2012, MMWR, 63(26) 563-568; TN Department of Health Controlled Substance Monitoring Database, 2015.

The following map graphically depicts the level of opioid usage across the state.

Morphine milligram equivalents dispensed and reported to the CSMD

Source: Tennessee Department of Health Controlled Substance Monitoring Database, 2015

Map 4. Opioid[1] morphine milligram equivalents dispensed and reported to the CSMD (MME; per capita): 2014

The project represents a unique opportunity to develop a comprehensive, innovative, holistic model of care for this patient population by bringing together the local academic and research resources of ETSU; coupled with the medical care expertise and capital resources of MSHA. Together, these two entities have formed ETHHI, a local not-for-profit company that will in turn also partner with Frontier Health to provide therapeutic and recovery based services.

This OTP will be only one component of a larger Center that will incorporate education, outreach, research, and evaluation, all aimed at making a truly significant difference in the management of this chronic disease of addiction. Evidence-based interventions activities and studies will be utilized to help address the very complex disease state associated with heroin, morphine, and prescription opioid abuse.

Both ETSU and MSHA have long-time roots in the community. East Tennessee State University, founded in 1911, is a state-supported, coeducational institution governed by the Tennessee Board of Regents, the sixth largest higher education system in the country. Chartered in 1909 as East Tennessee State Normal School, the institution became East Tennessee State Teachers College in 1925 and, five years later, State Teachers College, Johnson City. Beginning in 1943, the institution was known as East Tennessee State College for 20 years. Now known as ETSU, it currently has a student population of approximately 15,000 undergraduate, graduate and professional students. ETSU provides outstanding programs of study, enhanced access to education, and distinctive educational and research opportunities to attract students from around the region and the world. Although the majority of students are from Tennessee and the surrounding southeastern region, over 45 states and over 75 foreign countries are also represented. The main campus is located in Johnson City, Tennessee with satellite campuses in Kingsport, Elizabethton, and Sevierville. ETSU has a very strong health care focus with colleges of pharmacy, clinical and rehabilitative health sciences, nursing, public health, and medicine.

Mountain States Health Alliance is a large, integrated, not-for-profit health care system based in Johnson City, Tennessee. Founded in 1998, MSHA has historical community roots in the Johnson City Medical Center (JCMC) (1980-Present), Memorial Hospital (1951-1980), and Appalachian Hospital (1911-1951). The hospital system includes thirteen hospitals providing a core of acute care, hospital-based services, and an array of supporting services. In addition, MSHA operates urgent care centers, outpatient facilities, laboratory and radiology services, physician practices, long-term care and rehabilitation facilities, and community-based prevention and educational activities to a population of over 1.1 million residents of southern and central Appalachia.

Founded in 1957, Frontier Health provides behavioral health services, offering treatment for mental health, co-occurring, and substance abuse problems, recovery and vocational rehabilitation, and developmental and intellectual disabilities services. Frontier Health has 64 professionally staffed facilities located in 12 counties throughout Northeast Tennessee and Southwest Virginia.

The proposed OTP will be one component, albeit an integral component, of ETSU's Center for Prescription Drug Abuse Prevention and Treatment. Per the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) the two most common medicines used in Tennessee OTPs are methadone and buprenorphine. This OTP will initially be limited to the provision of methadone as its medication assisted treatment option. The service area will consist of the following counties: Carter, TN; Greene, TN; Hancock, TN; Hawkins, TN; Johnson, TN; Sullivan, TN; Unicoi, TN; Washington, TN; Lee, VA; Scott, VA; and Washington, VA (including the City of Bristol). There are currently no other non-residential methadone clinics in the proposed service area and the residents of these counties do not have convenient access to treatment outside of the area.

The proposed OTP projects 17 staff to be in place by the second full year of operation. The proposed OTP will adhere to the Personnel and Staffing Requirements of the Rules of the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). The OTP is projected to have a loss of ($326,421) on 650 patients in Year 1 and a positive bottom line of $956,425 with 1,050 patients in Year 2.

SUPPLEMENTAL #1
May 25, 2016
10:45 a.m.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. **Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.**

If the project involves none of the above, describe the development of the proposal.

RESPONSE:

The proposed project involves the establishment of a non-residential substitution-based treatment clinic for opiate addiction. The OTP will be located in approximately 7,851 square feet of medical office space at 203 Gray Commons Circle, Johnson City, TN. The site is located approximately 1 mile west from exit 13 of I-26 on TN-75 S. Bobby Hicks Highway/Suncrest Drive. Gray Commons is a planned, multi-use commercial development site envisioned by the City of Johnson City and Mountain States Health Alliance as an economic development driver for the Gray, TN community. The development includes 38 acres of developable land (MSHA owns 36.2 acres while the City of Johnson City owns 2.6 acres). The specific site for the OTP is a single-story building with ample parking for staff and patients. The only other lot developed in Gray Commons to date is occupied by Johnson City Fire Station 8 and is located in a lot across the street from the site, in the center of Gray Commons Circle. Gray Commons is otherwise surrounded by vacant land.

The site is owned by Mountain States Properties, Inc. and was previously leased to MSHA's medical management group for a family practice and an urgent care. The space will be redesigned to meet the necessary requirements and needs of an OTP.

The proposed project will not add any major medical equipment and will cost $1,747,777. The total construction costs will be $196,275 or $25.00 a square foot.

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

RESPONSE:
Not Applicable. This is a request to establish a new non-residential Opioid Treatment Program (OTP) which will be part of the larger research-based Center.

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
								Construction		
B. Unit/Depart. GSF Sub-Total			6,391	6,391	6,391		6,391	$25.00		$159,775
C. Mechanical/ Electrical GSF			204	204	204		204	$25.00		$5,100
D. Circulation /Structure GSF			1,256	1,256	1,256		1,256	$25.00		$31,400
E. Total GSF			7,851	7,851	7,851		7,851	$25.00		$196,275

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. ***Non-Residential Methadone Treatment Centers***
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

RESPONSE:

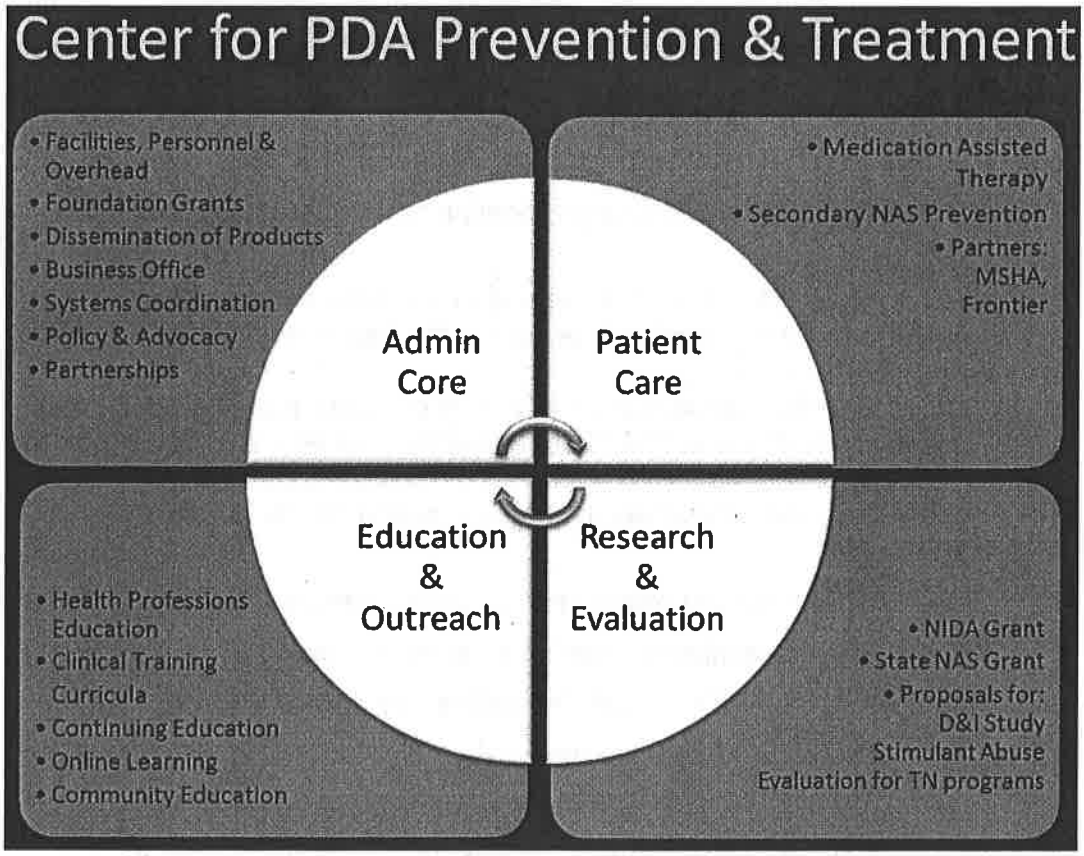
The establishment of a certified OTP in Washington County addresses a major epidemic plaguing this region of Northeast Tennessee and Southwest Virginia. While Washington and Sullivan counties are ranked 14th and 16th in income among counties in the state, they are among the very worst in morbidity associated with prescription drug abuse. For example, among the 10 counties with the greatest number of charges for hospital and emergency room treatment for drug dependence (not including alcohol), drug abuse (not alcohol) and opioid-related poisonings, Sullivan ranked first and Washington third with 10.8 and 7.9 charges at a rate of $56,000 to $61,000 in costs, per 1,000 people, respectively.[1] Also, in 2011, the last year for which the State has complete data, Sullivan County was highest in the state and Washington County third highest at 27.6 and 22.3 diagnosed drug poisonings per 1,000 people in each county, respectively. Finally, more than 800 infants in Tennessee were born experiencing withdrawal from addictive drugs in 2013. Over 60% of the infant's mothers were prescribed opioid painkillers, or the primary substance causing NAS, by a healthcare provider.[2] Washington County has the 5th (17 per 1,000) and Sullivan County has the 6th highest (15 per 1,000) ratio of NAS/live births in the state over the 2007-2011 time period. Clearly, out of 95 counties in the state, the Northeastern Tennessee region is in great need of evidence-based treatment and prevention programming to address the prescription drug abuse epidemic.

[1] Reagan, D.R., State data regarding NAS, treatment admissions, billing, overdose and PDA/M., Personal Communication to R. Pack, 2013.

[2] TDH. Drug Dependent Newborns (Neonatal Abstinence Syndrome) Update: Sept 29 2014]; http://health.state.tn.us/MCH/PDFs/NAS/NASsummary_Week_3814.pdf

In order to address this very complex and challenging healthcare and societal problem, an innovative model will be created to bring ETSU's academic health sciences education and research resources together with the operational expertise of local area providers (including MSHA and Frontier Health). This model will be based treatment options across the continuum of addiction; the OTP is only one component of a larger Center focused intently on research, education, prevention, and outreach aimed at combating one of the most devastating and wide-reaching challenges in the community.

The Center for Prescription Drug Abuse Prevention and Treatment is envisioned to be the nationally recognized leader in the inter-professional treatment for and prevention of prescription drug abuse. The Center will be made up of four main component elements that represent key areas for addressing the opioid addiction problem. They are the Administrative Core, the Treatment Core, the Research and Evaluation Core and The Education and Outreach Core. The following graphic illustrates the focus areas of the Center.



The proposed OTP will address the Patient Care component of the Center and it will include clinically valid treatment options that are coupled with comprehensive wrap-around services including extensive counseling and therapy as well as care management resources (such as support for social needs such employment placement, housing, and so forth) all provided utilizing various evidence-based approaches that work at different points along the continuum of addiction.

Furthermore, the Center will incorporate additional components including clinical training, community education and outreach, and research and evaluation all focused on reducing the prevalence of prescription drug abuse in the local region. Staff from these additional components will be housed in adjacent space to the clinic. This will enable those staff to be involved in the provision of care, training of students, and participation in active research associated with the proposed OTP.

The service area will consist of the following counties: Carter, TN; Greene, TN; Hancock, TN; Hawkins, TN; Johnson, TN; Sullivan, TN; Unicoi, TN; Washington, TN; Lee, VA; Scott, VA; and Washington, VA (including the City of Bristol). There are currently no other non-residential methadone clinics in the proposed service area. TDMHSAS notes there are currently 12 licensed clinics in TN with the nearest two both located in Knoxville. The proposed project represents an innovative opportunity to increase access to this much needed clinical option, but it also is part of a larger Center providing a more effective system of care to address the prescription drug epidemic.

D. Describe the need to change location or replace an existing facility.

RESPONSE:
Not Applicable. This is a request to establish a new non-residential Opioid Treatment Program (OTP) which will be part of the larger research-based Center.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $2.0 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):
   a. Describe the new equipment, including:
      1. Total cost; (As defined by Agency Rule).
      2. Expected useful life;
      3. List of clinical applications to be provided; and
      4. Documentation of FDA approval.
   b. Provide current and proposed schedules of operations.

RESPONSE:
Not Applicable. This is a request to establish a new non-residential Opioid Treatment Program (OTP) which will be part of the larger research-based Center.

2. For mobile major medical equipment:

a. List all sites that will be served;

b. Provide current and/or proposed schedule of operations;

c. Provide the lease or contract cost.

d. Provide the fair market value of the equipment; and

e. List the owner for the equipment.

RESPONSE:
Not Applicable. This is a request to establish a new non-residential Opioid Treatment Program (OTP) which will be part of the larger research-based Center.

3. Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

RESPONSE:
Not Applicable. This is a request to establish a new non-residential Opioid Treatment Program (OTP) which will be part of the larger research-based Center.

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which **must include**:

1. Size of site (***in acres***);
2. Location of structure on the site; and
3. Location of the proposed construction.
4. Names of streets, roads or highway that cross or border the site.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

RESPONSE:
The proposed project involves the establishment of a non-residential substitution-based treatment clinic for opiate addiction. The OTP will be located in approximately 7,851 SF of medical office space at 203 Gray Commons Circle, Johnson City, TN. The site is located approximately 1 mile west from exit 13 of I-26 on TN-75 S. Bobby Hicks Highway/Suncrest Drive. Included in Attachment B.III.(A) is the plot plan for this site which is located on 36.2 acres.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

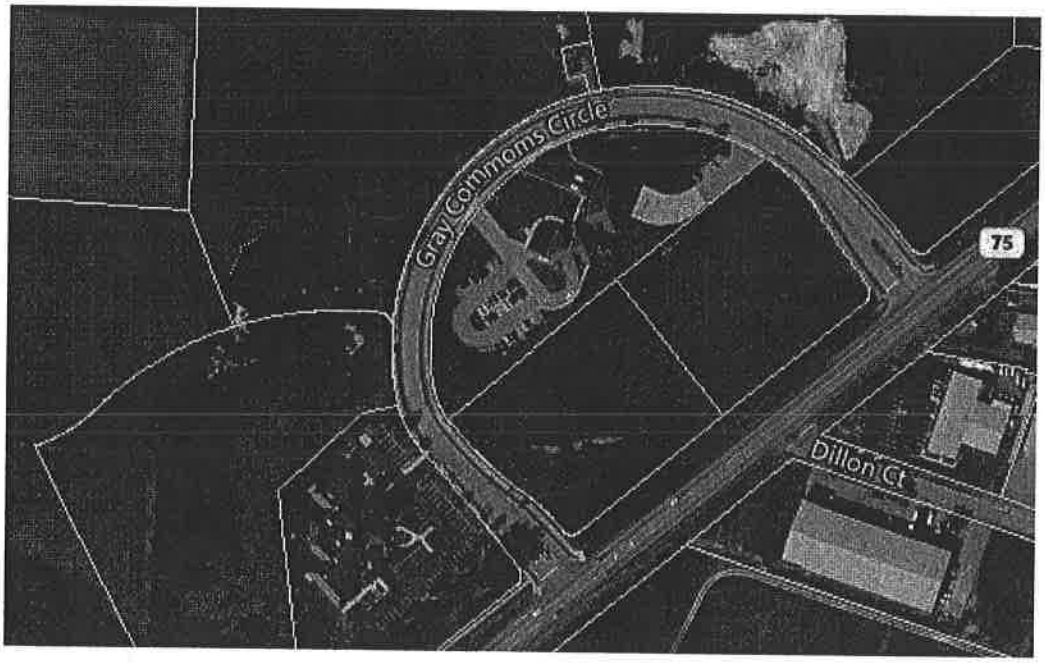
RESPONSE:

The proposed project involves the establishment of a non-residential substitution-based treatment clinic for opiate addiction. The OTP will be located in approximately 7,851 SF of medical office space at 203 Gray Commons Circle, Johnson City, TN. The site is located approximately 1 mile west from exit 13 of I-26 on TN-75 S. Bobby Hicks Highway/Suncrest Drive. Gray Commons is a planned, multi-use commercial development site envisioned by the City of Johnson City and Mountain States Health Alliance as an economic development driver for the Gray, TN community. The development includes 38 acres of developable land (MSHA owns 36.2 acres while the City of Johnson City owns 2.6 acres). The specific site for the OTP is a single-story building with ample parking for staff and patients. The only other lot developed in Gray Commons to date is occupied by Johnson City Fire Station 8 and is located in a lot across the street from the site, in the center of Gray Commons Circle. Gray Commons is otherwise surrounded by vacant land.

This location is easily accessible from I-26 as well as I-81, both major interstates that serve this region with I-81 connecting Tennessee to Virginia (north to south) and I-26 connected Tennessee to North Carolina, (east to west).

Given that there are no existing providers in the proposed service area, patients must utilize their own transportation resources to drive to out of area providers, which can be as far as Knoxville, TN (over 100 miles away from Johnson City), Cedar Bluff, VA (over 90 miles away from Johnson City), Weaverville, NC (over 45 miles away from Johnson City), and Boone, NC (over 55 miles away from Johnson City). Public transportation is not currently an option and while there is not public transportation directly available at this site, it is significantly closer than the alternative out of area providers.

A satellite image of the building which would house the proposed project is provided below (the building to the lower left hand corner).



IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

NOTE: ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

RESPONSE:
Floor plans for the project are provided in Attachment B.IV.

V. For a Home Health Agency or Hospice, identify:

1. Existing service area by County;
2. Proposed service area by County;
3. A parent or primary service provider;
4. Existing branches; and
5. Proposed branches.

RESPONSE:
Not Applicable.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.

a. Please discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan. Please list each principle and follow it with a response.

Principle 1: The purpose of the State Health Plan is to improve the health of Tennesseans.

RESPONSE:
Establishing a non-residential substitution-based addiction clinic in Washington County will improve the health of Tennesseans in the service area. These services are essential to a well-developed healthcare delivery system and the collaborative relationship with ETSU and other area providers such as Frontier Health will expand the service offerings to include a local, certified OTP which is not currently available within the service area.

Principle 2: Every citizen should have reasonable access to health care.

RESPONSE:
The proposed OTP will create a local access point for those who are in need of these services. Without a local option, patients have to endure lengthy daily drive times or forgo treatment, which is not appropriate for this population. According to a recent study funded by the National Institutes of Health (NIH), only about 25 percent of people who had ever had drug abuse disorder received care.

Principle 3: The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system.

RESPONSE:
Local collaboration between MSHA, ETSU, Frontier Health and other area providers will create a more seamless and effective health care delivery system in the local market. Access to critically needed services which are currently unavailable in the service area will complete a missing component and thereby create a more robust local system of care. The proposed OTP will be designed to provide the most efficient, highest quality, and clinically appropriate services.

Principle 4: Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.

RESPONSE:
Given the commitments of both MSHA and ETSU to the success of the project, the Agency and the community can be confident that the proposed OTP will meet and maintain stringent clinical standards.

Principle 5: The state should support the development, recruitment and retention of a sufficient and quality health care workforce.

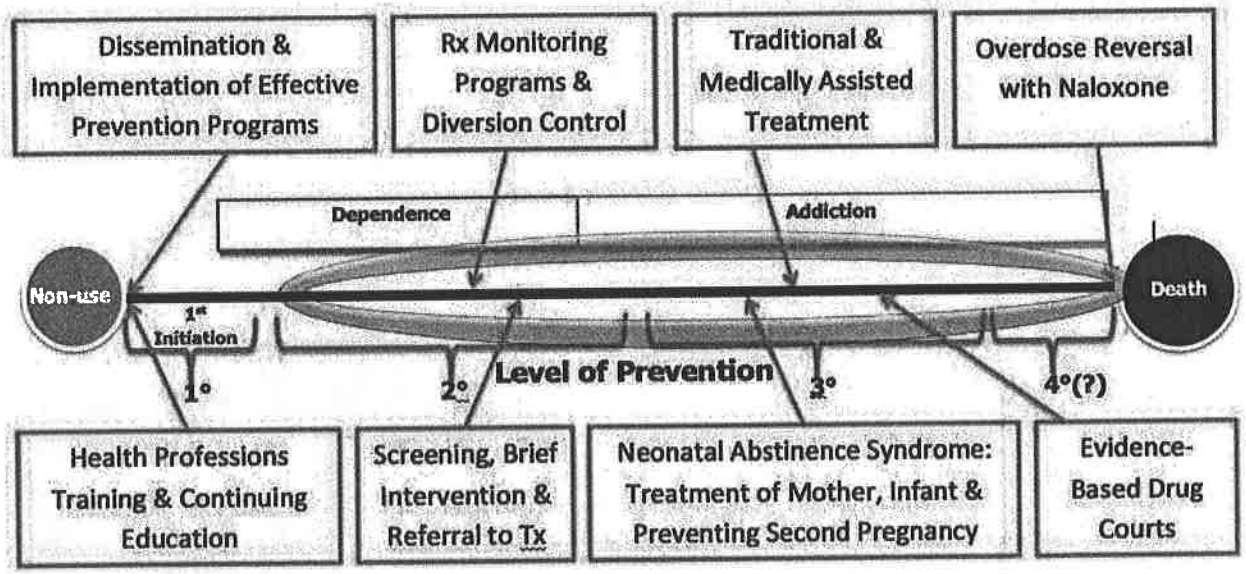
RESPONSE:
With the involvement of ETSU in the proposed OTP, there is opportunity to incorporate students and interns for training purposes. This could range from nursing students, social work interns, and counseling students which are all existing programs available at ETSU.

b. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9 of the Guidelines for Growth) here.

Special Criteria for Non-Residential Methadone Treatment Facilities (NRMTF)

A non-residential narcotic treatment facility should provide adequate medical, counseling, vocational, educational, mental health assessment, and social services to patients enrolled in the opioid treatment program with the goal of the individual becoming free of opioid dependency.

RESPONSE:
This innovative partnership between ETSU and MSHA will provide for a unique model of care to address this very challenging disease of addiction. There are many evidence-based tools that must be used to fully address the problem. A systems-level approach to enacting those tools is needed in order to truly bend the curve. The following figure is illustrative of the expansive scope of the problem and profiles the evidence-based approaches to reduce prescription drug abuse.



In the figure, the continuum is anchored on the left with Non-use and on the right with Death. The "danger zone" is in the red oval in the center. Empirically validated interventions are placed according to the level of dependence/addiction that call for their use. For example, the dissemination of effective prevention programs is warranted for youth that have never initiated prescription drug abuse. Hence, primary prevention efforts are focused on non-users. Toward the other extreme, prescription monitoring programs are effective in reducing 'doctor-shopping' among those who are dependent or addicted to prescription narcotics. Skipping to the top right of the diagram, the promotion of naloxone to reverse opiate overdose should be expanded for widespread adoption by those that need it. The certified OTP is only one component, albeit an integral one, along this continuum (as reflected in the "Traditional & Medically Assisted Treatment.") The difficulty with the opioid addiction problem is that by using only one strategy, the relative impact on the consequences of the whole epidemic is small. A coordinated systems-

level approach is needed to truly alter the course of this epidemic. Medical, counseling, vocational, educational, mental health assessment and social services to patients will absolutely be provided to patients of the proposed OTP along with a plethora of other evidence-based support.

40

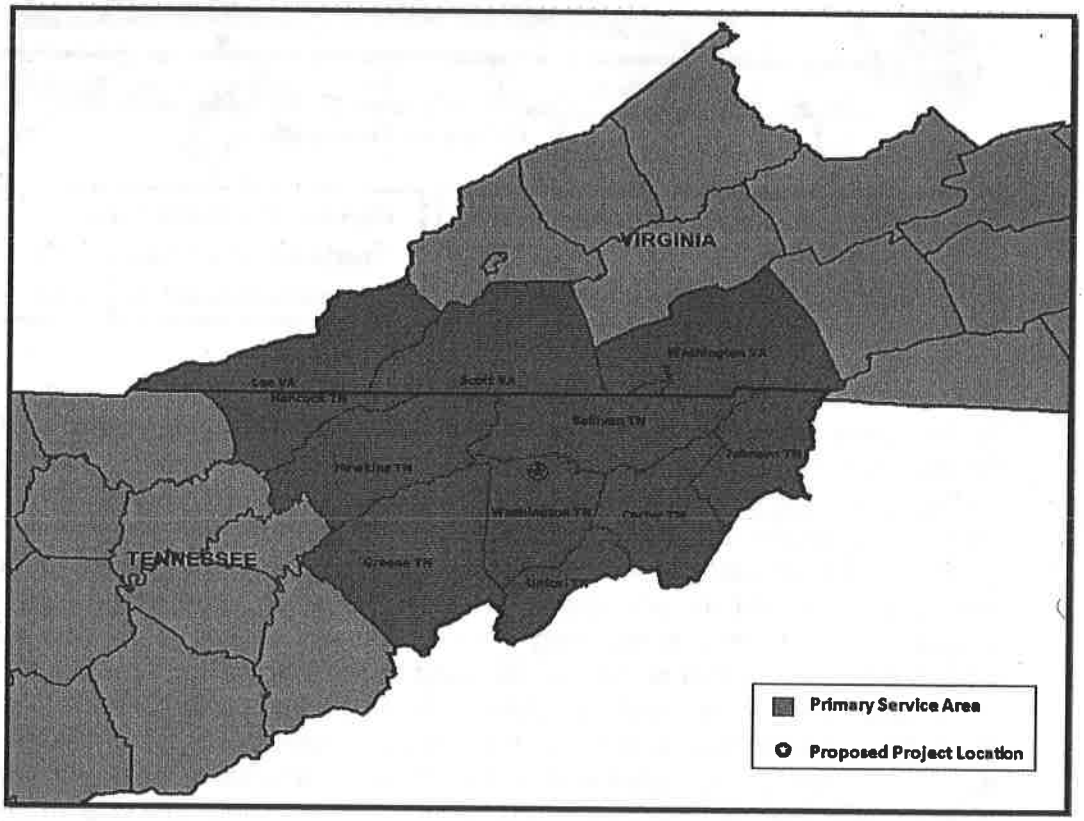
Need

The need for non-residential narcotic treatment facilities should be based on information prepared by the applicant for a certificate of need which acknowledges the importance of considering the demand for services along with need and addressing and analyzing service problems as well.

RESPONSE:
As noted previously, this certified OTP will be only one component of a much more robust Center aimed at providing a comprehensive and innovative approach to serving the needs of this population. Research and evaluation resources of ETSU will be available to do "real-time" research on actual clinical care practices for the opioid dependent population. This real-world research will substantiate established care practices and evaluate the efficacy of new ones.

The assessment should cover the proposed service area and include the utilization of existing service providers, scope of services provided, patient origin, and patient mix.

RESPONSE:
The proposed service area consists of 11 counties and one locality, including Carter, TN; Greene, TN; Hancock, TN; Hawkins, TN; Johnson, TN; Sullivan, TN; Unicoi, TN; Washington, TN; Lee, VA; Scott, VA; Washington, VA; and Bristol City, VA. A map of the proposed service area is provided below.



The proposed project intends to offer two medication-assisted therapy options for its patients, methadone and buprenorphine. The proposed OTP intends to focus first on the provision of methadone and then expand into buprenorphine. The following provides an overview and comparison of these two options.

From a historical perspective, methadone was originally developed in Germany during the 1930s as a synthetic alternative to opium. Post World War II, the United States obtained all research records for the substance and noted that it was less sedating and less of a respiratory depressant than morphine. In 1947, Methadone was approved by the FDA for the treatment of opioid dependence.

Methadone is considered a form of opioid replacement therapy and was used to help patients transition off of more addictive opioids like heroin. For a long time, methadone was considered the preeminent opioid replacement therapy option. Eventually, Reckitt Benckiser Pharmaceuticals developed the drug Suboxone (buprenorphine), a partial opioid agonist as a competitor to methadone. Suboxone became available in 2002 and is regarded similar in efficacy to methadone, but more favorable in that it has a reduced potential for abuse. The table below provides a comparison of these two options.

Drug type	Synthetic Opioid (Full agonist)	Synthetic opioid (Partial agonist)
Approved uses	Opioid dependence.	Opioid dependence.
Ingredients	Methadone Hydrochloride	Buprenorphine (80%) / Naloxone (20%); or Buprenorphine
Formats	Dropper. Oral concentrate. Oral solution. Tablet.	Sublingual film. Tablet.
Dosages	Dropper: 30 ml of 10 mg/ml + Oral concentrate: 10 mg/ml + Oral solution: 5 mg/5ml or 10 mg/5ml + Tablet: 5 mg/10 mg/40 mg	Sublingual film: 2 mg/0.5 mg or 4 mg/1 mg or 8 mg/2 mg or 12 mg/3 mg + Tablet: 2 mg/0.5 mg or 8 mg/2 mg
Manufacturer	Eli Lilly & Company	Reckitt Benckiser Pharmaceuticals
Legal Status	Schedule II (US)	Schedule III (US)
Generic version?	Yes.	Yes.
Half life	**8 to 59 hours**	**24 to 42 hours**
Common side effects	Constipation. Dizziness. Drowsiness. Dry mouth. Lightheadedness. Nausea. Sweating. Vomiting.	Constipation. Dizziness. Drowsiness. Dry mouth. Lightheadedness. Nausea. Sweating. Vomiting.
Date approved	**(1947)**	**October (2002)**
Effect duration	24 to 36 hours (Analgesic: 6 to 8 hours)	24 hours (Analgesic: 8 to 12 hours)

Methadone and Suboxone are similar in that they are both synthetic opioids engineered as a replacement option for those addicted to illicit drugs like heroin. Although the side effect profile associated with each drug is similar, there are many differences between the two drugs. Methadone is regarded as a full mu-opioid receptor agonist, whereas Suboxone is considered a partial agonist.

The fact that Suboxone is a partial agonist makes it less potent than the full agonist that is methadone. Suboxone has less potential for abuse due to the fact that it was engineered with a ceiling effect. This means that when taken at increasingly higher doses, a user will not derive any additional psychological euphoria from Suboxone as they will from methadone.

A meta-analysis published in 2014 evaluated all randomized controlled trials of buprenorphine and methadone compared to a placebo for the management of opioid dependence. The goal of this research was to determine whether one substance was safer and/or more effective than the other.

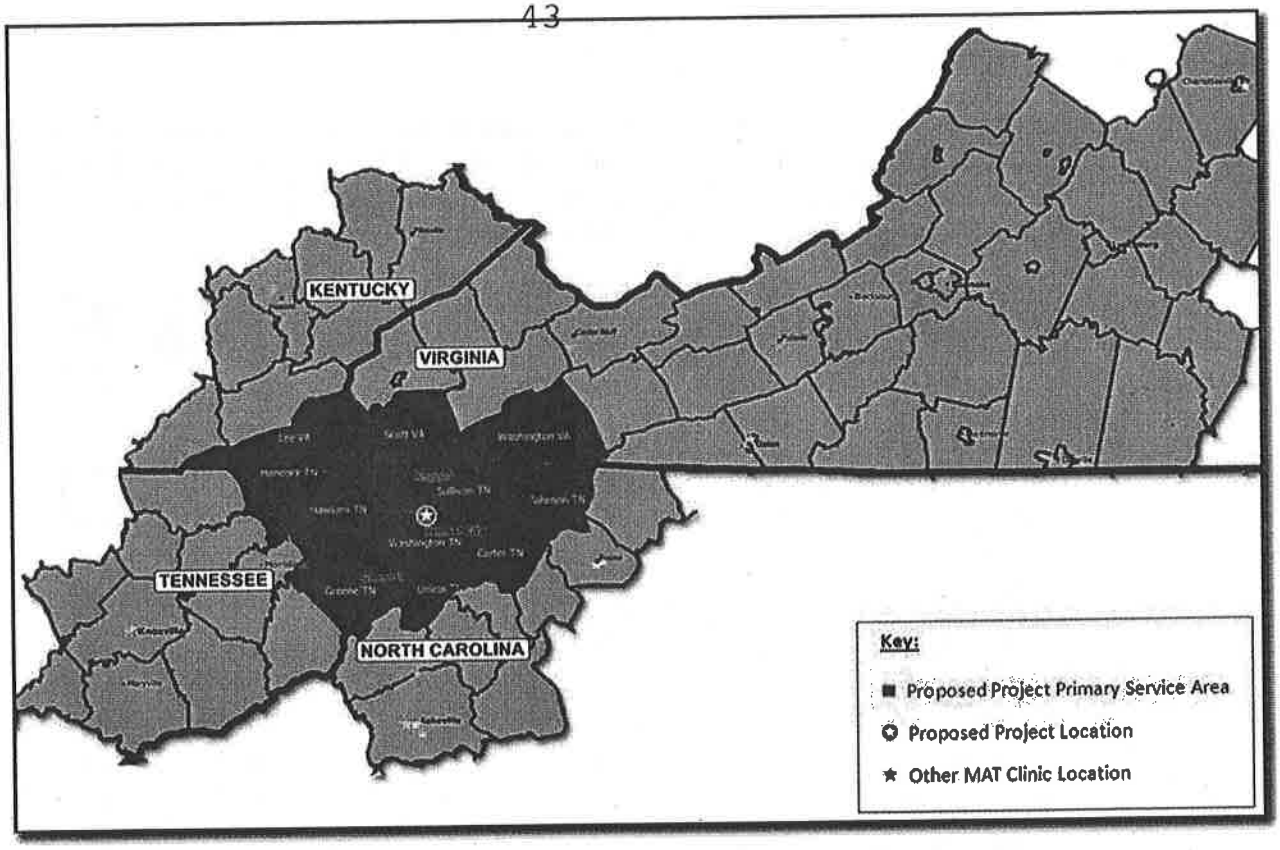
The researchers included 31 trials with a cumulative total of 5,430 individuals. The study authors determined that buprenorphine was effective in maintenance treatment of heroin dependence at doses above 2 mg. It also suppressed illicit opioid usage when administered at doses exceeding 16 mg.

Methadone was considered more effective than Suboxone for treatment retention when used flexibly at low fixed quantities. At medium and high doses, there was no significant difference in treatment retention and both drugs suppressed the usage of illicit opioids. Due to the fact that doses are often used flexibly and are seldom "fixed" in clinical practice, the authors suggested that methadone leads to greater treatment retention.

That said, both drugs were equally effective at suppressing illicit opioid use. If Suboxone is being used at a fixed medium or high dose, there shouldn't be much of a difference in regards to treatment-retention or efficacy compared to Methadone. However, if Suboxone is being used at flexible doses, particularly within the range of 2 mg to 6 mg, treatment retention is often poorer compared to Methadone.

Source: http://www.ncbi.nlm.nih.gov/pubmed/18425880

There is a role for both treatment options along the continuum of addiction for opioid users. Currently there are no certified OTPs providing methadone within the proposed service area. The map provided below and in Attachment C.I.1 profiles OTP programs surrounding the proposed service area. A second map is included in Attachment C.I.2 profiling the location of the 12 existing OTPs in the state of Tennessee, again none of which are located in the proposed service area. There are however, a significant number of physician's authorized to prescribe buprenorphine to treat opioid dependency, with 120 identified through the Substance Abuse and Mental Health Services Administration (SAMHSA) website. A listing of these providers is also provided in Attachment C.I.2



Data from the Tennessee Department of Mental Health and Substance Abuse Services indicates that in 2012, there were 9,221 Tennessee residents who sought treatment at an OTP in the state. With a total 2012 population of 6,361,070 this equates to a use rate of 145.0 per 100,000. By applying that rate of potential use to the population of the service area indicates that the region has at least 950 potential OTP patients. This analysis applies the Tennessee use rate to a service area that includes several counties in Virginia as they are part of the proposed service area. Application of the Tennessee use rate does not distort the projected need, because East TN has comparatively high rates of opioid addiction. Therefore the estimate is likely very conservative. Further, the estimate is based on 2012 data and does not account for any significant growth of opioid abuse in recent years.

Service Area Total Population	643,005	655,045
2012 TN Use Rate per 100,000	145.0	145.0
Estimated Number of OTP Patients	932	950

Source: 2014 report from the TN Department of Mental Health and Substance Abuse Services and others entitled "Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee"

A substantial number of people currently do not seek treatment as there is no local OTP option and geographic inaccessibility is a barrier. Because of the breadth of services associated with the larger Center focused on research, evaluation, prevention, education, outreach and treatment, the applicant anticipates a population will seek services here that have not previously sought treatment for various reasons. Furthermore, the applicant's intention to explore direct contracting with TennCare and to possibly participate with Medicare and commercial payors, could expand the accessibility

of this service to populations previously unable to maintain the private pay requirements of existing out of area providers.

For these reasons, coupled with the prevalence of opioid addiction in the region, an adjusted use rate of 165 per 100,000 was utilized to project volume. This was applied to the total population for each county in the proposed service area. The table below details the projected patient population by county.

County	Total Projected Pts		% Distribution	
	Yr 1 2018	Yr 2 2019	Yr 1 2018	Yr 2 2019
Carter, TN	96	96	9%	9%
Greene, TN	121	121	11%	11%
Hancock, TN	12	12	1%	1%
Hawkins, TN	98	98	9%	9%
Johnson, TN	31	31	3%	3%
Sullivan, TN	263	263	25%	24%
Unicoi, TN	31	31	3%	3%
Washington, TN	227	230	21%	21%
Lee, VA	38	38	4%	4%
Scott, VA	37	37	3%	3%
Washington, VA	90	90	8%	8%
Bristol City, VA	26	26	2%	2%
Service Area Total	**1,070**	**1,075**	**100%**	**100%**

Note: this reflects patients who would be engaged in the methadone option for their substitution based treatment; buprenorphine will be added as a second treatment option in Year 3.

The assessment should consider that the users of opiate drugs are the clients at non-residential narcotic treatment facilities, and because of the illegal nature of opiate drug use, data will be based on estimates, actual counts, arrests for drug use, and hospital admittance for drug abuse.

RESPONSE:

The applicant recognizes that the data used to estimate need is based on actual counts of the state-wide methadone use rate for opioid addiction applied to a service area that has historically a higher prevalence of both opioid morphine milligram equivalents (MME) dispensed per capita as well as buprenorphine MME dispended per capita compared to the rest of the state, which is illustrated in the table below. The data provided below includes only a subset of the proposed service area, but is illustrative of the point that the need estimation for the proposed project likely underestimates the actual need in the proposed service area.

County	Buprenorphine MME per capita (a)	Dispensed Opioid MME per capita (b)
Carter, TN	478	1,073
Greene, TN	299	1,313
Hancock, TN	579	1,726
Hawkins, TN	478	1,604
Johnson, TN	242	875
Sullivan, TN	378	1,143
Unicoi, TN	391	1,200
Washington, TN	323	837
TN Overall	115	901

(a) Excludes VA pharmacies
(b) Excludes VA pharmacies as well as buprenorphine products approved by FDA indicating for treatment of opioid dependence
Source: TN Department of Mental Health and Substance Abuse (TDMHSAS)

The assessment should also include:

1. *A description of the geographic area to be served by the program;*

RESPONSE:
The proposed service area consists of 11 counties and one locality, including Carter, TN; Greene, TN; Hancock, TN; Hawkins, TN; Johnson, TN; Sullivan, TN; Unicoi, TN; Washington, TN; Lee, VA; Scott, VA; Washington, VA; and Bristol City, VA.

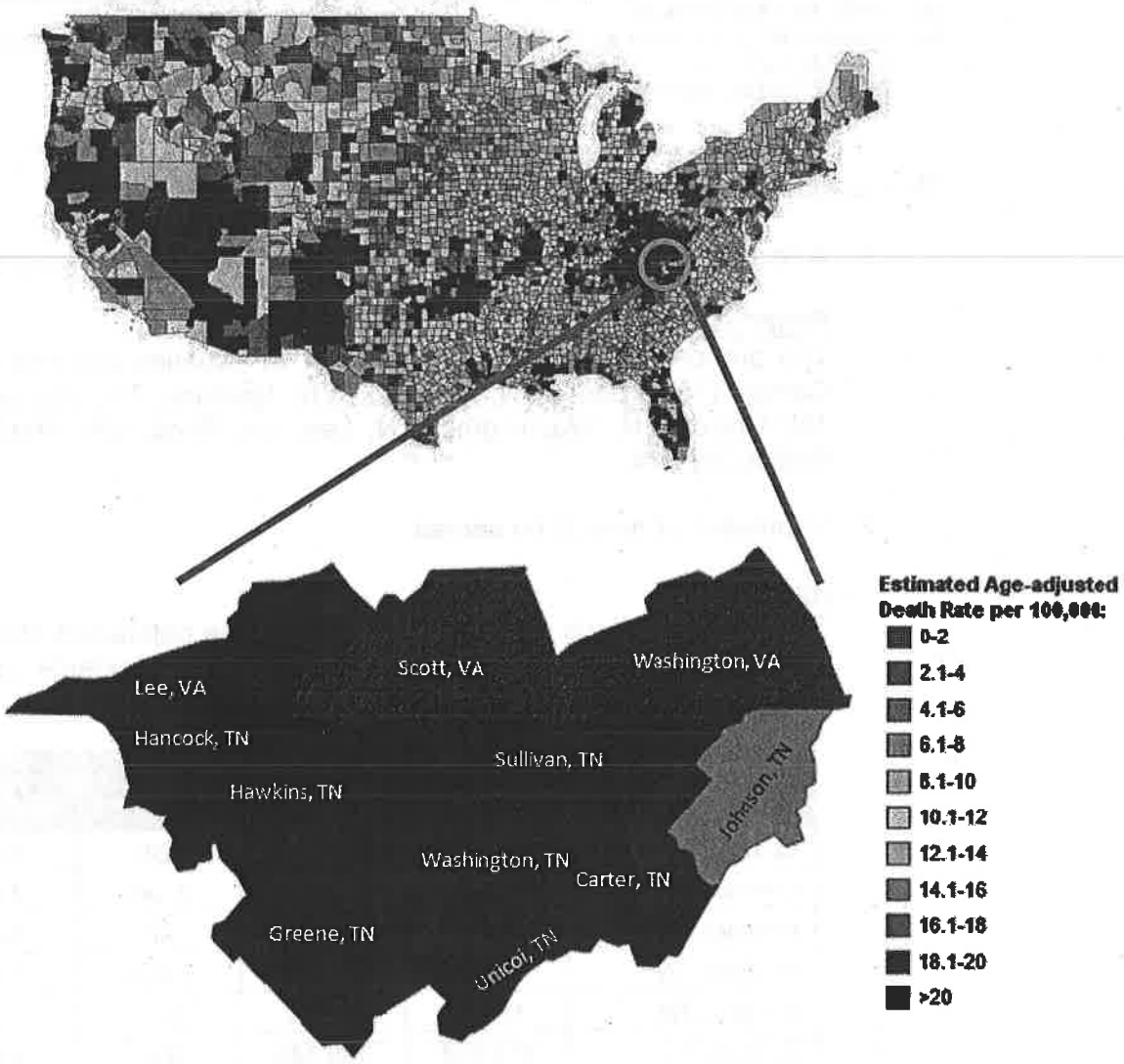
2. *Population of area to be served;*

RESPONSE:
The following charts note the distribution of the population across the proposed service area. There are approximately 650,000 residents across the service area.

TOTAL	2016 Population	2020 Population	2016-2020 Growth Number	2016-2020 Growth Percent
Carter, TN	58,139	58,375	236	0.4%
Greene, TN	72,512	74,656	2,144	3.0%
Hancock, TN	6,951	7,007	56	0.8%
Hawkins, TN	58,771	59,784	1,013	1.7%
Johnson, TN	18,793	19,112	319	1.7%
Sullivan, TN	158,938	159,749	811	0.5%
Unicoi, TN	18,847	19,150	303	1.6%
Washington, TN	133,817	140,905	7,088	5.3%
Lee, VA	23,195	23,193	-2	0.0%
Scott, VA	22,295	22,271	-24	-0.1%
Washington, VA	54,749	54,887	138	0.3%
Bristol City, VA	15,998	15,957	-41	-0.3%
Service Area Total	**643,005**	**655,045**	**12,040**	**1.9%**

3. *The estimated number of persons, in the described area, addicted to heroin or other opioid drugs and an explanation of the basis of the estimate;*

RESPONSE:
This region has experienced a near epidemic of death rates for drug poisoning. As illustrated in the map below (which is also provided in Attachment C.I.3), the proposed service area has some of the highest death rates for drug poisoning across the entire country. This map provided the estimated age adjusted death rates for drug poisoning in 2014. The map also details the rate within the proposed service area.



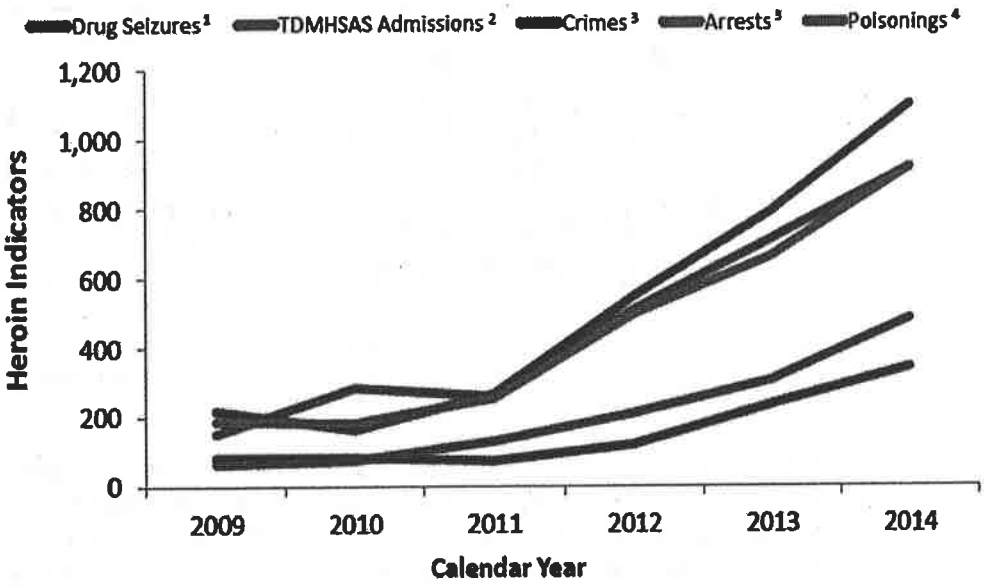
Source: Centers for Disease Control and Prevention/National Center for Health Statistics, Vital Statistics System

Unfortunately heroin is a growing challenge across the state as well. The following data compiled by the State Epidemiology Outcomes Workgroup (with members from TDH, TDMHSAS, ETSU, Vanderbilt University and others) from

multiple sources illustrates the increasing drug seizures, admissions, crimes, arrests, and drug poisonings associated directly with heroin.

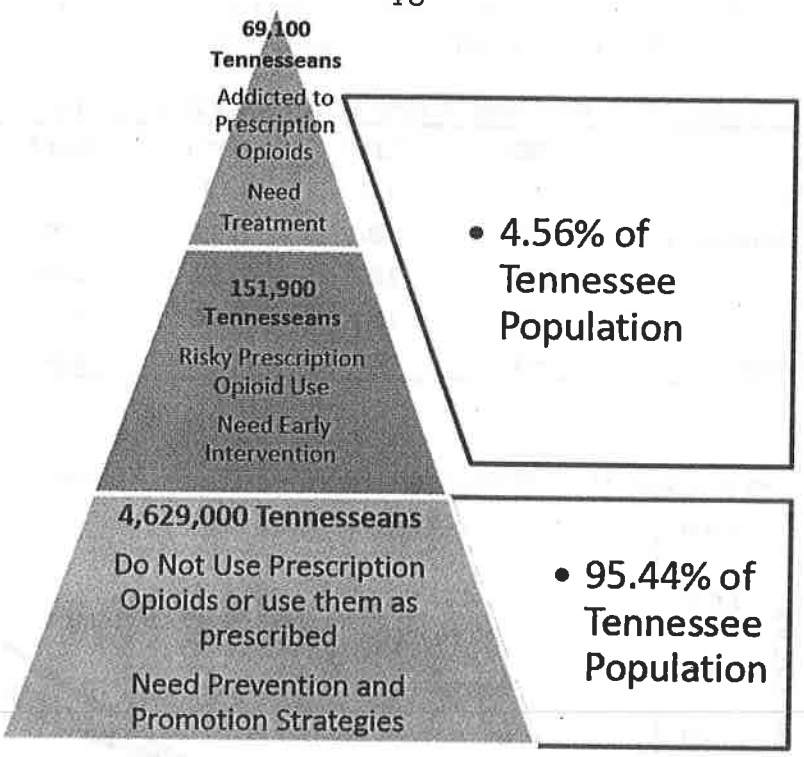
Table 1. Compilation of heroin indicators: Tennessee 2009-2014

Year (CY)	2009	2010	2011	2012	2013	2014
Drug Seizures[1]	82	82	73	120	235	341
TDMHSAS Admissions[2]	152	284	259	509	712	917
Crimes[3]	218	162	266	548	793	1,098
Arrests[3]	187	182	254	496	663	917
Drug Poisonings	64	74	129	210	305	482



Sources: TN Bureau of Investigation Lab Data, 2015; TDMHSAS WITS, 2015; TN Bureau of Investigation CJIS Support Center, 2015; TN Department of Health, Division of Policy, Planning, and Assessment's Hospital Discharge Data System, 2009-2013, 2014 provisional.

According to a 2014 report from the TN Department of Mental Health and Substance Abuse Services and others entitled "Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee", a survey of Tennesseans reveals the increased use of prescription opioids in the state. Of the 4.85 million adults in Tennessee, it is estimated that 4.56% (221,000) have used pain relievers in the past year for non-medical purposes. Of those adults, it is estimated that 69,100 are addicted to prescription opioids and require treatment for prescription opioid abuse. The other 151,900 are using prescription opioids in ways that could be harmful and may benefit from early intervention strategies. This rate applied to the population of the proposed service area (643,005 in 2016) indicates approximately 29,000 individuals are in need of early intervention or treatment for addiction to prescription opioids.



Source: 2014 report from the TN Department of Mental Health and Substance Abuse Services and others entitled "Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee"

The proposed project is part of a much more comprehensive model than currently exists today. This is only one component of a larger Center for Prescription Drug Abuse Prevention and Treatment (ETSU). The Center is engaged with key stakeholders in the region with respect to mental health, substance abuse services, provision of medication-assisted treatment and other clinical substance use disorder services. The Center was recently approved by the Tennessee Board of Regents and is envisioned to be the nationally recognized leader in inter-professional treatment for the prevention of prescription drug abuse and misuse. The Center will focus on research and evaluation of evidence based practice targeting not just the 4.56 percent of the state's population who are already either engaged in risky prescription opioid use and need early intervention or are addicted to prescription opioids and need treatment, but just as importantly the other 95.44 percent of the state's population who do not use prescription opioids but need prevention and promotion strategies.

4. *The estimated number of persons, in the described area, addicted to heroin or other opioid drugs presently under treatment in methadone and other treatment programs;*

RESPONSE:

Data from the Tennessee Department of Mental Health and Substance Abuse Services indicates that in 2012, there were 9,221 Tennessee residents who sought treatment at an OTP in the state. With a total 2012 population of 6,361,070 this equates to a use rate of 145.0 per 100,000. By applying that rate of potential use to the population of the service area indicates that the region has at least 950 potential OTP patients. This analysis applies the

Tennessee use rate to a service area that includes several counties in Virginia as they are part of the proposed service area. Application of the Tennessee use rate does not distort the projected need, because East TN has comparatively high rates of opioid addiction. Therefore the estimate is likely very conservative. Further, the estimate is based on 2012 data and does not account for any significant growth of opioid abuse in recent years.

Service Area Total Population	643,005	655,045
2012 Use Rate per 100,000	145.0	145.0
Estimated Number of OTP pts	932	950

5. *Projected rate of intake and factors controlling intake;*

RESPONSE:
The proposed OTP projects that the rate of intake will be approximately 60 patients per month in Year 1. The factors controlling intake include the mix of transfer patients versus new patients, who require more time to admit) and the rate at which new patients become aware of the program.

6. *Compare estimated need to existing capacity.*

RESPONSE:
With approximately 29,000 from the proposed service area defined as potentially in need of treatment or early intervention for prescription drug abuse, there is substantiated need for additional services. There are no certified OTPs in the proposed service area, forcing patients to travel long distances daily for their substitution therapy (methadone). Further, this model represents a unique partnership between two local entities – ETSU and MSHA. Other area providers such as Frontier Health will also be involved. This represents a tremendous opportunity for a much broader system of care to be provided to this challenging and complex patient population.

Also, consideration should be given to the reality that existing facilities can expand or reduce their capacity to maintain or treat patients without large changes in overhead.

RESPONSE:
While existing facilities can flex their capacity to meet fluctuating need, this is an opportunity to remove the geographic barrier that currently exists for the proposed service area. The closest OTPs from the surrounding area are located between 32 minutes to 89 minutes in drive time one way. This proposed project would dramatically reduce that time for the residents in the proposed service area. This is a unique, innovative model designed around evidence-based care and includes an intensive focus not only on treatment, but on expansive therapy/counseling services with case management expertise to assist with housing, employment, and other social needs. The applicant will also seek to contract directly with TennCare and to participate in Medicare and commercial plans as allowable.

Service Area

The geographic service area should be reasonable and based on an optimal balance between population density and service proximity.

RESPONSE:

The service area was selected based on an assessment of the drive times to other OTP programs in Tennessee, Virginia, North Carolina and Kentucky. It was determined that the proposed location in Johnson City, Tennessee would be the closest option for the proposed service area. There are a total of 18 OTPs in the surrounding region which are identified in a map in Attachment C.I.2. Of those 18 existing OTPs, six represented the closest current option. Those include OTPs in Knoxville, TN; Cedar Bluff, VA; Weaverville, NC; Boone, NC; and Pikeville, KY. The drive time to these various providers was compared against drive time to the proposed site in Johnson City. Based on this assessment the service area was defined to include 11 counties and one locality, including Carter, TN; Greene, TN; Hancock, TN; Hawkins, TN; Johnson, TN; Sullivan, TN; Unicoi, TN; Washington, TN; Lee, VA; Scott, VA; Washington, VA; and Bristol City, VA. The table following summarizes this drive time assessment. For each county, the most populous city was identified and used for the drive time assessment. The sites color-coded in yellow represent those closest to each populous city. The sites color-coded in orange represent the second closest to each populous city.

City	County	Proposed Site	Other Nearby MAT Centers					
		★ 203 Grey Commons Circle, Johnson City, TN	TN - DBO Knoxville Medical Clinic Central (Clinic)	VA - Galax Treatment Center, Inc Cedar Bluff	NC - Crossroads Treatment Center of Weaverville, PC	NC - McLeod Addictive Disease Center - Boone	NC - Stepping Stones Wellness Center, LLC Boone	KY - BHG XXV, LLC Pikeville
Johnson City TN	Washington, TN	15 min/11.2 mi	95 min/107 mi	96 min/91.4 mi	45 min/45.6 mi	85 min/58.3 mi	79 min/55.4 mi	129 min/118 mi
Kingsport TN	Sullivan, TN	19 min/15.6 mi	90 min/99 mi	87 min/66.3 mi	67 min/69.3 mi	111 min/80.9 mi	103 min/78.0 mi	108 min/95.1 mi
Bristol TN	Sullivan, TN	31 min/27.6 mi	101 min/113 mi	69 min/55.8 mi	75 min/69.1 mi	93 min/69.7 mi	88 min/68.5 mi	129 min/111 mi
Mountain City TN	Johnson, TN	71 min/55.0 mi	146 min/155 mi	90 min/70.1 mi	93 min/79.1 mi	40 min/26.8 mi	35 min/25.6 mi	154 min/125 mi
Elizabethton TN	Carter, TN	29 min/20.2 mi	109 min/115 mi	93 min/82.1 mi	56 min/52.3 mi	71 min/47.3 mi	65 min/46.1 mi	142 min/127 mi
Greeneville TN	Greene, TN	44 min/28.8 mi	66 min/70.6 mi	115 min/105 mi	69 min/47.5 mi	132 min/89.6 mi	126 min/86.7 mi	148 min/136 mi
Erwin TN	Unicoi, TN	28 min/25.6 mi	107 min/101 mi	109 min/105 mi	82 min/81.2 mi	91 min/59.0 mi	85 min/56.1 mi	141 min/132 mi
Rogersville TN	Hawkins, TN	48 min/41.4 mi	73 min/73.4 mi	114 min/93.1 mi	97 min/95.2 mi	139 min/108 mi	133 min/105 mi	138 min/122 mi
Sneedville, TN	Hancock, TN	83 min/64.1 mi	85 min/69.1 mi	132 min/102 mi	134 min/118 mi	175 min/131 mi	168 min/128 mi	125 min/99.8 mi
Abingdon VA	Washington, VA	42 min/42.2 mi	111 min/128 mi	48 min/41.7 mi	89 min/95.9 mi	80 min/55.0 mi	75 min/53.8 mi	112 min/96.9 mi
Duffield, VA	Scott, VA	46 min/39.0 mi	113 min/124 mi	92 min/76.6 mi	93 min/92.8 mi	133 min/105 mi	127 min/103 mi	77 min/71.3 mi
Pennington Gap, VA	Lee, VA	65 min/54.4 mi	127 min/101 mi	107 min/90.1 mi	113 min/108 mi	154 min/121 mi	147 min/118 mi	89 min/78.0 mi

Source: Google Maps

Closest MAT location

2nd closest MAT location

It should be noted that while Stepping Stones in Boone, NC is actually a closer option to Mountain City, TN in Johnson County, a review of the inpatient trends of that county indicate that 80 percent travel to a Tennessee hospital for inpatient care and only 14 percent travel to a North Carolina hospital. This illustrates a strong affinity of residents to seek care in Tennessee as opposed to North Carolina. For that reason, Johnson County was included as part of the proposed service area. The table below profiles the market share trends for acute inpatients admitted from Johnson County. It compares the distribution of patients who were admitted to a Tennessee, North Carolina, or Virginia hospital between 2012 and 2014.

	Total Inpatients			Market Share		
Hospital State	CY2012	CY2013	CY2014	CY2012	CY2013	CY2014
NC	389	316	339	17%	14%	14%
TN	1,843	1,887	1,891	80%	82%	80%
VA	83	105	144	4%	5%	6%
Grand Total	**2,315**	**2,308**	**2,374**	**100%**	**100%**	**100%**

Sources: THA, VHHA, and NC state database.
Note: excludes normal newborns, inpatient rehabilitation, substance abuse and psychiatric patients

The more comprehensive chart that details the drive time of all the surrounding OTPs is provided in Attachment C.I.4.

The relationship of the socio-demographics of the service area and the projected population to receive services should be considered. The proposal's sensitivity to and the responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, and low-income groups.

RESPONSE:

Compared to the state of Tennessee, the demographics of the proposed OTP's service area are similar in terms of gender (51 percent female, 49 percent male). The service area counties have a much lower median household income compared both Tennessee and Virginia, $35,422 for the service area versus $44,361 for Tennessee and $64,902 for Virginia. The racial mix in the primary service area is predominately Caucasian, accounting for more than 92 percent of the population. The proposed service area demographics across the areas of gender and racial and ethnic minorities are relatively consistent with Tennessee and Virginia (although the service area is much less diverse compared to the rest of the country).

The largest socio-demographic challenges in the proposed service area relate to the significantly lower levels of income as well as education. The applicant is proposing that 5 percent of its revenues will be for the charity care population (a rate higher than other projects which have previously applied in the service area). Regarding TennCare, it will cover methadone for only a very limited population, those enrollees who are 18 to 20 years of age. Given the unique mission of this proposed OTP, the applicant plans to explore opportunities with TennCare to contract directly to meet the needs of a broader age span for both methadone and buprenorphine.

Relationship to Existing Applicable Plans

The proposals' estimate of the number of patients to be treated, anticipated revenue from the proposed project, and the program funding source with description of the organizational structure of the program delineating the person(s) responsible for the program, should be considered.

RESPONSE:

The applicant projects 650 patients in the first year and 1,050 in the second year of operations. These volumes reflect only those patients who would be receiving methadone as their part of their substitution based therapy for opioid addiction. The program does plan to add buprenorphine as a second option for those patients for whom

this is a more appropriate treatment.[52] Since this will not be done until the third year of operations, that patient population is not reflected in the above numbers.

The anticipated revenues include a loss of $326,421 in the first year of operation and a positive bottom line of $956,425 in the second year of operations. This is a unique model that involves a not-for-profit corporation (East Tennessee Healthcare Holding, Inc.) which is jointly created by MSHA and ETSU. This entity, in conjunction with other area partners such as Frontier Health, is focused on providing a broad span of care for those addicted to heroin, morphine and prescription opioids. This certified OTP will be only one component of a much larger Center that will focus on research, evaluation, education, prevention, outreach as well as treatment. Therefore, any gains from this certified OTP will be reinvested into the larger Center for Prescription Drug Abuse Prevention and Treatment (ETSU), after MSHA recoups the capital expenditures it has invested into the OTP. If approved, MSHA will manage the certified OTP and will cover the anticipated first year losses.

As this program is in developmental phase, the organizational structure is still being determined as is the person responsible for the program. Given the commitments of both MSHA and ETSU to the success of the project, the Agency can be confident that clinical leadership of the project will meet and maintain stringent clinical standards. For example, the medical director will likely be an addictionologist or someone with similar qualifications.

The proposals' relationship to policy as formulated in local and national plans, including need methodologies, should be considered.

RESPONSE:
The proposed OTP will be part of the Center for Prescription Drug Abuse Prevention and Treatment, which is led by a team of scientists and practitioners that are trained in finding and disseminating evidence-based programs for implementation. The central theme of the Center's work is that of concordance with local, state and national plans and helping the state make informed choices about next steps for policy development. As a concrete example, the Center assisted the local Washington County Mayor and government with development of an evidence based workforce health promotion policy and training for division leaders on an evidence based tool for substance use risk reduction in the workplace. The Center Director was trained at the National Institutes of Health Training Institute for Dissemination and Implementation Research in Health, and is a member of the State Epidemiology Outcomes Workgroup. Every year since 2012, the research team from ETSU has attended and presented their data at the National Rx Abuse and Heroin Summit. The proposed OTP will be part of the Center and will work toward local, state and national plans.

The proposals' relationship to underserved geographic areas and underserved population groups, as identified in local plans and other documents, should be a significant consideration.

RESPONSE:

The largest socio-demographics challenges in the proposed service area relate to the significantly lower levels of income as well as education. The applicant is proposing that 5 percent of its revenues will be for the charity care population (a rate higher than other projects which have previously applied in the service area). Regarding TennCare, it will cover methadone for only a very limited population, those enrollees who are 18 to 20 years of age. Given the unique mission of this proposed OTP, the applicant plans to

explore opportunities with TennCare to contract directly to meet the needs of a broader age span for both methadone and buprenorphine.

The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

RESPONSE:
The applicant is not aware of any similar services that are supported by state appropriations.

The degree of projected financial participation in the Medicare and TennCare programs should be considered.

RESPONSE:
The intent behind this proposed project is to meet the needs of the community and the region. This is a unique endeavor which involves a joint undertaking by ETSU and MSHA to create a not-for-profit OTP. To the best of the applicant's knowledge none of the existing 12 OTPs in the state accept Medicare or TennCare/Medicaid. This proposed OTP, if approved, will diligently pursue coverage for treatments to Medicare and TennCare patients.

While the coverage of medication-assisted therapy by Medicare is complicated, the applicant intends to accept Medicare to the extent possible. Medicare does not appear to cover methadone when provided in an outpatient clinic nor do Part D plans cover methadone to treat substance abuse (only for pain). Initial research indicates that buprenorphine treatment costs are typically not covered by Medicare unless the treatment is provided in an inpatient or outpatient treatment center. It may also be covered in some instances, such as during detoxification or early stage stabilization. However, the Medicare benefit does not usually cover typical office-based buprenorphine induction or maintenance treatment visits.

In some instances, Medicare Part D may cover the cost of the buprenorphine tablets themselves. Only some Medicare providers will reimburse (including Healthnet Orange, Silverscript, and Wellcare) and prior authorization is usually required.

Regarding TennCare, it will cover methadone for only a very limited population, those enrollees who are 18 to 20 years of age. Given the unique mission of this proposed OTP, the applicant plans to explore opportunities with TennCare to contract directly to meet the needs of a broader age span for both methadone and buprenorphine.

While it is the applicant's intention to fully explore options for the participation in Medicare and TennCare for both buprenorphine and methadone, given the uncertainty regarding the extent to which the applicant will be successful, it is not possible to quantify the number of patients who may be covered by these programs. Therefore, the proposed payor mix does not include any Medicare or TennCare/Medicaid.

c. Applications that include a Change of Site for a health care institution (one having an outstanding and unimplemented CON), provide a response to General Criterion and Standards (4)(a-c)

RESPONSE:

Not Applicable.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

RESPONSE:
The proposed certified OTP will be only one component of the larger Center for Prescription Drug Abuse Prevention and Treatment. It is the long-term vision of the Center to establish a research center for multi-level prevention and treatment of prescription drug abuse to serve the region. The Center will serve as a central coordination point for the prevention and treatment of prescription drug abuse, improving the health of the citizens in the region, expanding scientific knowledge in an area of significant national importance, and both directly and indirectly enhancing economic development in Central Appalachia. It is anticipated that the Center will not only help reduce prescription drug abuse in the region, but also serve as a vital source of information for other parts of the country also dealing with this problem.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

RESPONSE:
The service area was selected based on an assessment of the drive times to other OTP programs in Tennessee, Virginia, North Carolina and Kentucky. It was determined that the proposed location in Johnson City, Tennessee would be the closest option for the proposed service area. There are a total of 18 OTPs in the surrounding region which are identified in a map in Attachment C.I.2. Of those 18 existing OTPs, six represented the closest current option. Those include OTPs in Knoxville, TN; Cedar Bluff, VA; Weaverville, NC; Boone, NC; and Pikeville, KY. The drive time to these various providers was compared against drive time to the proposed site in Johnson City. Based on this assessment the service area was defined to include 11 counties and one locality, including Carter, TN; Greene, TN; Hancock, TN; Hawkins, TN; Johnson, TN; Sullivan, TN; Unicoi, TN; Washington, TN; Lee, VA; Scott, VA; Washington, VA; and Bristol City, VA. The table following summarizes this drive time assessment. For each county, the most populous city was identified and used for the drive time assessment. The sites color-coded in yellow represent those closest to each populous city. The sites color-coded in orange represent the second closest to each populous city.

City	County	Proposed Site	Other Nearby MAT Centers					
		★ 203 Gray Commons Circle, Johnson City, TN	TN - D&D Knoxville Medical Clinic Central (Cecil)	VA - Galax Treatment Center, Inc Cedar Bluff	NC - Crossroads Treatment Center of Weaverville, PC	NC - McLeod Addictive Disease Center - Boone	NC - Stepping Stones Wellness Center, LLC, Boone	KY - BNG XXV, LLC Pikeville
Johnson City TN	Washington, TN	15 min/11.2 mi	95 min/107 mi	96 min/91.4 mi	45 min/45.6 mi	85 min/58.3 mi	79 min/55.4 mi	129 min/118 mi
Kingsport TN	Sullivan, TN	19 min/15.6 mi	90 min/99 mi	87 min/66.3 mi	67 min/69.3 mi	111 min/80.9 mi	103 min/78.0 mi	108 min/95.1 mi
Bristol TN	Sullivan, TN	31 min/27.6 mi	101 min/113 mi	65 min/55.8 mi	75 min/69.1 mi	93 min/69.7 mi	88 min/68.5 mi	129 min/111 mi
Mountain City TN	Johnson, TN	71 min/55.0 mi	146 min/155 mi	90 min/70.1 mi	93 min/79.1 mi	40 min/26.8 mi	35 min/25.6 mi	154 min/125 mi
Elizabethton TN	Carter, TN	29 min/20.2 mi	109 min/115 mi	93 min/82.1 mi	56 min/52.3 mi	71 min/47.3 mi	65 min/46.1 mi	142 min/127 mi
Greeneville TN	Greene, TN	44 min/28.8 mi	66 min/70.6 mi	115 min/105 mi	69 min/47.5 mi	132 min/89.6 mi	126 min/86.7 mi	148 min/136 mi
Erwin TN	Unicoi, TN	28 min/25.6 mi	107 min/101 mi	109 min/105 mi	32 min/31.2 mi	91 min/59.0 mi	85 min/56.1 mi	141 min/132 mi
Rogersville TN	Hawkins, TN	48 min/41.4 mi	73 min/73.4 mi	114 min/93.1 mi	97 min/95.2 mi	139 min/108 mi	133 min/105 mi	138 min/122 mi
Sneedville, TN	Hancock, TN	83 min/64.1 mi	85 min/69.1 mi	132 min/102 mi	134 min/118 mi	175 min/131 mi	168 min/128 mi	125 min/99.8 mi
Abingdon VA	Washington, VA	42 min/42.2 mi	111 min/128 mi	48 min/41.7 mi	89 min/95.9 mi	80 min/55.0 mi	75 min/53.8 mi	112 min/96.9 mi
Duffield, VA	Scott, VA	46 min/39.0 mi	113 min/124 mi	92 min/76.6 mi	93 min/92.8 mi	133 min/105 mi	127 min/103 mi	77 min/71.3 mi
Pennington Gap, VA	Lee, VA	65 min/54.4 mi	127 min/101 mi	107 min/90.1 mi	113 min/108 mi	154 min/121 mi	147 min/118 mi	89 min/78.0 mi

Source: Google Maps

Closest MAT location

2nd closest MAT location

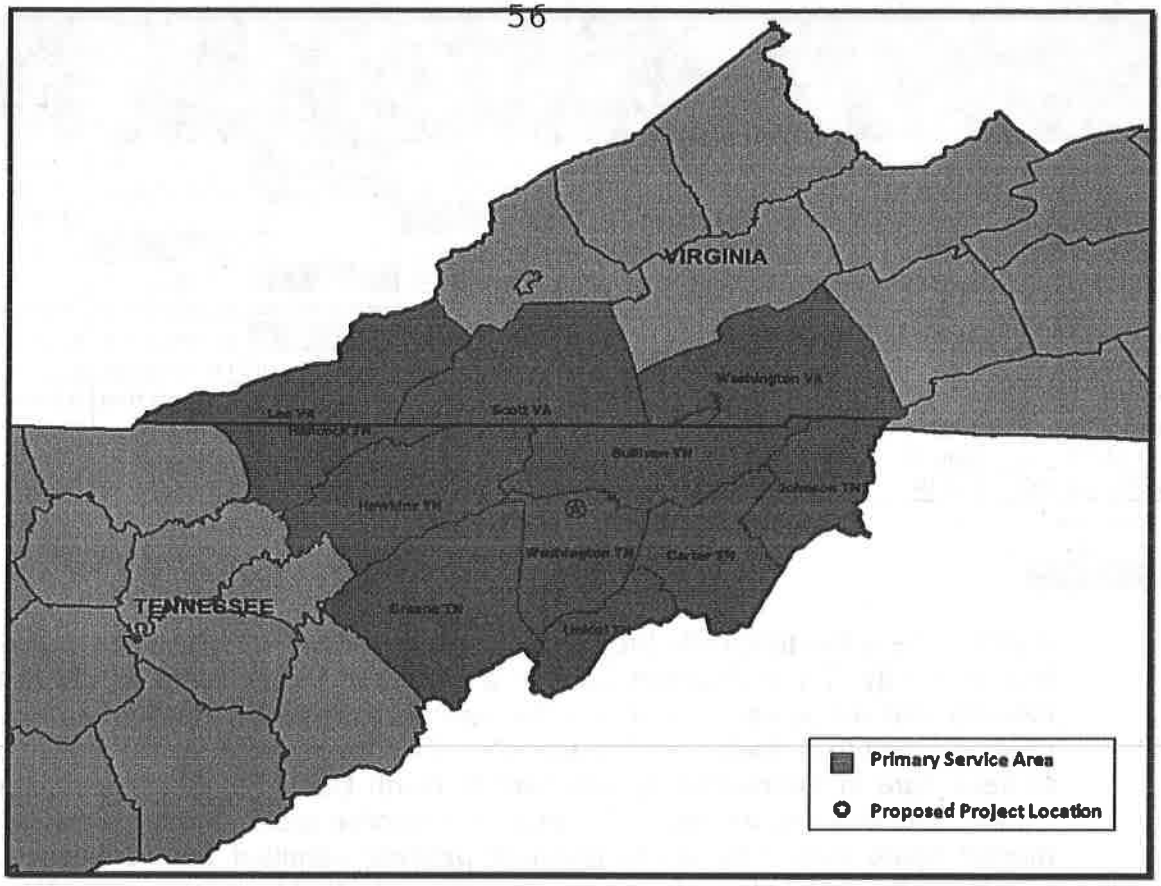
It should be noted that while Stepping Stones in Boone, NC is actually a closer option to Mountain City, TN in Johnson County, a review of the inpatient trends of that county indicate that 80 percent travel to a Tennessee hospital for inpatient care and only 14 percent travel to a North Carolina hospital. This illustrates a strong affinity of residents to seek care in Tennessee as opposed to North Carolina. For that reason, Johnson County was included as part of the proposed service area. The table below profiles the market share trends for acute inpatient patients admitted from Johnson County. It compares the distribution of patients who were admitted to a Tennessee, North Carolina, or Virginia hospital between 2012 and 2014.

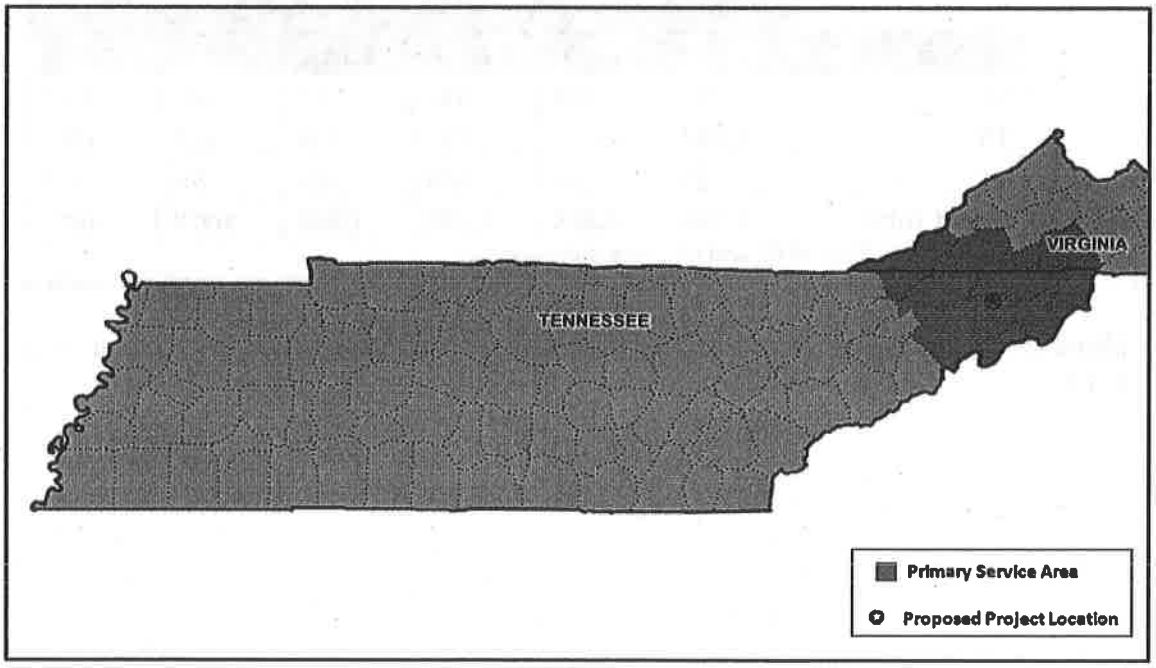
	Total Inpatients			Market Share		
Hospital State	CY2012	CY2013	CY2014	CY2012	CY2013	CY2014
NC	389	316	339	17%	14%	14%
TN	1,843	1,887	1,891	80%	82%	80%
VA	83	105	144	4%	5%	6%
Grand Total	**2,315**	**2,308**	**2,374**	**100%**	**100%**	**100%**

Sources: THA, VHA, and NC state database.

Note: excludes normal newborns, rehabilitation, substance abuse and psychiatric patients

Maps depicting the service area are provided on the following pages as well as in Attachment C.I.1.


VIRGINIA
TENNESSEE
Primary Service Area
Proposed Project Location


VIRGINIA
TENNESSEE
Primary Service Area
Proposed Project Location

4. A. Describe the demographics of the population to be served by this proposal.

RESPONSE:

The following table shows the total population of each of the counties in the project's service area. Analysis of the data predicts a 1.9 percent growth in the service area of the OTP from 2016 to 2020. In addition, the OTP will be located in Washington County, which expects a 5.3 percent growth over the next 5 years.

TOTAL	2016 Population	2020 Population	2016-2020 Growth Number	2016-2020 Growth Percent
Carter, TN	58,139	58,375	236	0.4%
Greene, TN	72,512	74,656	2,144	3.0%
Hancock, TN	6,951	7,007	56	0.8%
Hawkins, TN	58,771	59,784	1,013	1.7%
Johnson, TN	18,793	19,112	319	1.7%
Sullivan, TN	158,938	159,749	811	0.5%
Unicoi, TN	18,847	19,150	303	1.6%
Washington, TN	133,817	140,905	7,088	5.3%
Lee, VA	23,195	23,193	-2	0.0%
Scott, VA	22,295	22,271	-24	-0.1%
Washington, VA	54,749	54,887	138	0.3%
Bristol City, VA	15,998	15,957	-41	-0.3%
Service Area Total	**643,005**	**655,045**	**12,040**	**1.9%**
TENNESSEE	**6,812,005**	**7,108,031**	**296,026**	**4.3%**
VIRGINIA	**8,468,697**	**8,811,512**	**342,815**	**4.0%**

Within the service area, a higher growth rate is expected among adults (the population to be served by this proposed project) compared to the total population, as demonstrated by the following table.

ADULT Ages 20 and Up	2016 Population	2020 Population	2016-2020 Growth Number	2016-2020 Growth Percent
Carter, TN	45,476	46,030	554	1.2%
Greene, TN	56,305	58,604	2,299	4.1%
Hancock, TN	5,375	5,463	88	1.6%
Hawkins, TN	45,063	46,420	1,357	3.0%
Johnson, TN	15,106	15,550	444	2.9%
Sullivan, TN	123,857	125,345	1,488	1.2%
Unicoi, TN	14,764	15,146	382	2.6%
Washington, TN	103,542	109,541	5,999	5.8%
Lee, VA	18,369	18,387	18	0.1%
Scott, VA	17,697	17,712	15	0.1%
Washington, VA	42,981	43,167	186	0.4%
Bristol City, VA	12,525	12,525	0	0.0%
Service Area Total	**501,060**	**513,889**	**12,829**	**2.6%**
TENNESSEE	**5,052,454**	**5,302,540**	**250,086**	**4.9%**
VIRGINIA	**6,339,997**	**6,596,642**	**256,645**	**4.0%**

A demographic snapshot of the project's service area which was prepared by Sg2 is included in Attachment C.I.5. Sg2 is an international healthcare company which provides analytics (including demographics and utilization projections), intelligence, consulting and educational services to over 1,200 organizations around the world. Their analytics-based health care expertise helps hospitals and health systems integrate, prioritize and drive growth and performance across the continuum of care.

Compared to the state of Tennessee, the demographics of the proposed OTP's service area are similar in terms of gender (51 percent female, 49 percent male). The service area counties have a much lower median household income compared both Tennessee and Virginia, $35,422 for the service area versus $44,361 for Tennessee and $64,902 for Virginia. The racial mix in the primary service area is predominately Caucasian, accounting for more than 92 percent of the population.

Additional demographic information is also included in the following tables.

Variable	Carter, TN	Greene, TN	Hancock, TN	Hawkins, TN	Johnson, TN	Sullivan, TN	Unicoi, TN	Washington, TN
Current Year (2016), Age 65+[1]	12,124	15,550	1,470	12,112	4,060	34,510	4,491	24,231
Projected Year (2020), Age 65+	13,475	17,790	1,679	13,883	4,512	38,067	5,086	28,137
Age 65+, % Change	11.1%	14.4%	14.2%	14.6%	11.1%	10.3%	13.2%	16.1%
Age 65+, % Total (PY)	23.1%	23.8%	24.0%	23.2%	23.6%	23.8%	26.6%	20.0%
CY, Total Population	58,139	72,512	6,951	58,771	18,793	158,938	18,847	133,817
PY, Total Population	58,375	74,656	7,007	59,784	19,112	159,749	19,150	140,905
Total Pop. % Change	0.4%	3.0%	0.8%	1.7%	1.7%	0.5%	1.6%	5.3%
TennCare Enrollees[2]	13,679	16,202	2,435	14,406	4,753	34,938	4,280	25,262
TennCare Enrollees as a % of Total Population	23.5%	22.3%	35.0%	24.5%	25.3%	22.0%	22.7%	18.9%
Median Age[3]	43.2	43.4	44.2	42.8	43.9	44.1	45.4	39.7
Median Household Income[3]	32,754	35,860	26,528	37,432	31,711	39,577	34,346	42,935
Population % Below Poverty Level[3]	23.5%	22.1%	27.8%	17.0%	23.3%	18.0%	20.7%	17.9%

Variable	Lee, VA	Scott, VA	Washington, VA	Bristol City, VA	Service Area	Tennessee	Virginia
Current Year (2016), Age 65+[1]	4,471	4,907	11,356	3,334	132,616	1,091,516	1,306,289
Projected Year (2020), Age 65+	4,570	5,015	11,660	3,402	147,276	1,266,295	1,359,168
Age 65+, % Change	2.2%	2.2%	2.7%	2.0%	11.1%	16.0%	4.0%
Age 65+, % Total (PY)	19.7%	22.5%	21.2%	21.3%	22.5%	17.8%	15.4%
CY, Total Population	23,195	22,295	54,749	15,998	643,005	6,812,005	8,468,697
PY, Total Population	23,193	22,271	54,887	15,957	655,045	7,108,031	8,811,512
Total Pop. % Change	0.0%	-0.1%	0.3%	-0.3%	1.9%	4.3%	4.0%
TennCare Enrollees[2]	5,920	3,896	10,749		115,955	1,534,367	959,540
TennCare Enrollees as a % of Total Population	25.5%	17.5%	15.2%		22.0%	22.5%	11.3%
Median Age[3]	42.4	45.2	44.1	41.6	43.2	38.6	37.7
Median Household Income[3]	31,264	36,579	42,458	33,616	35,422	44,361	64,902
Population % Below Poverty Level[3]	26.0%	19.1%	12.3%	19.6%	20.6%	18.3%	11.8%

Sources: TN Population from TN Department of Health, VA State-level Population from Weldon Cooper Center, VA County-level Population from Sg2, TennCare enrollees from the Bureau of TennCare, VA Medicaid enrollees from CMS (state) and DRG - Decision Resource Group (county), and demographic information from the US Census Bureau

Notes:

[1] CY Virginia Age 65+ not available from Weldon Cooper Center, estimated using % of 65+ population in PY applied to CY total.

[2] Virginia Medicaid Enrollees provided for state of VA and VA counties; Bristol City, VA enrollees included in Washington, VA

[3] Service area figures for median age, median household income, and % population below poverty level are averages for the individual counties

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

RESPONSE:

Compared to the state of Tennessee, the demographics of the proposed OTP's service area are similar in terms of gender (51 percent female, 49 percent male). The service area counties have a much lower median household income compared both Tennessee and Virginia, $35,422 for the service area versus $44,361 for Tennessee and $64,902 for Virginia. The racial mix in the primary service area is predominately Caucasian, accounting for more than 92 percent of the population. The proposed service area demographics across the areas of gender and racial and ethnic minorities are relatively consistent with Tennessee and Virginia (although the service area is much less diverse compared to the rest of the country).

The largest socio-demographic challenges in the proposed service area relate to the significantly lower levels of income and education. The applicant is proposing that 5 percent of its revenues will be for the charity care population (a rate higher than other projects which have previously applied in the service area). Regarding TennCare, it will cover methadone for only a very limited population, those enrollees who are 18 to 20 years of age. Given the unique mission of this proposed OTP, the applicant plans to explore opportunities with TennCare to contract directly to meet the needs of a broader age span for both methadone and buprenorphine.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

RESPONSE:

The proposed project intends to initiate methadone as its first substitution based treatment option for opioid addiction and add buprenorphine in the third year operations.

Regarding methadone, of the 12 certified OTPs in Tennessee, none exist in the proposed service area nor are there are any Virginia OTPs in the proposed service area. A profile of the utilization for the last three years for the three closest OTPs in Tennessee is provided below. This information was obtained through a May 12, 2106 request to the TDMHSAS.

Utilization/Facility	DRD Knoxville Medical Clinic-Central (Citico Street location)	DRD Knoxville Medical Clinic-Bernard (Bernard Avenue location)	Volunteer Treatment Center (Chattanooga, TN)
2012 Patients	524	520	726
2013 Patients	651	639	1002
2014 Patients	964	923	1749
2012 Patient Visits	--	--	--
2013 Patient Visits	--	--	--
2014 Patient Visits	--	--	--
2012 Patients from 8 TN County Proposed Service Area Listed Above	9	10	1
2013 Patients from 8 TN County Proposed Service Area Listed Above	9	10	10
2014 Patients from 8 TN County Proposed Service Area Listed Above	9	10	10

Source: TDMHSAS, May 12, 2016

A substantial number of people are currently not seeking treatment as there is no local option and geographic inaccessibility is a barrier. Because of the breadth of services associated with the larger Center, which is focused on research, evaluation, prevention, education, outreach and treatment, the applicant anticipates a population will seek services here that have not previously sought treatment for various reasons. Furthermore, the applicant's intention to explore direct contracting with TennCare and possible participate with Medicare and commercial payors, could expand the accessibility of this services to populations previously unable to maintain the private pay requirements of existing out of area providers.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

RESPONSE:
Data from the Tennessee Department of Mental Health and Substance Abuse Services indicates that in 2012, there were 9,221 Tennessee residents who sought treatment at an OTP in the state. With a total 2012 population of 6,361,070 this equates to a use rate of 145.0 per 100,000. By applying that rate of potential use to the population of the service area indicates that the region has at least 950 potential OTP patients. This analysis applies the Tennessee use rate to a service area that includes several counties in Virginia as they are part of the proposed service area. Application of the Tennessee use rate does not distort the projected need, because East TN has comparatively high rates of opioid addiction. Therefore the estimate is likely very conservative. Further, the estimate is based on 2012 data and does not account for any significant growth of opioid abuse in recent years.

	2016	2020
Service Area Total Population	643,005	655,045
2012 TN Use Rate per 100,000	145.0	145.0
Estimated Number of OTP Patients	932	950

Source: 2014 report from the TN Department of Mental Health and Substance Abuse Services and others entitled "Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee"

A substantial number of people currently do not seek treatment as there is no local OTP option and geographic inaccessibility is a barrier. Because of the breadth of services associated with the larger Center focused on research, evaluation, prevention, education, outreach and treatment, the applicant anticipates a population will seek services here that have not previously sought treatment for various reasons. Furthermore, the applicant's intention to explore direct contracting with TennCare and possible participate with Medicare and commercial payors, could expand the accessibility of this services to populations previously unable to maintain the private pay requirements of existing out of area providers.

These reasons coupled with the prevalence of opioid addiction in the region, an adjusted use rate of 165 per 100,000 was utilized to project volume. This was applied to the total population for each county in the proposed service area. The table below details these calculations.

County	Total Population		Total Patient Pool		Total Projected Patients	
	Yr 1 2018	Yr 2 2019	Yr 1 2018	Yr 2 2019	Yr 1 2018	Yr 2 2019
Carter, TN	58,274	58,328	96	96	59	94
Greene, TN	73,075	73,620	121	121	73	119
Hancock, TN	6,981	6,996	12	12	7	11
Hawkins, TN	59,311	59,553	98	98	59	96
Johnson, TN	18,952	19,032	31	31	19	31
Sullivan, TN	159,393	159,584	263	263	160	257
Unicoi, TN	19,003	19,082	31	31	19	31
Washington, TN	137,400	139,160	227	230	138	224
Lee, VA	23,194	23,194	38	38	23	37
Scott, VA	22,287	22,283	37	37	22	36
Washington, VA	54,795	54,818	90	90	55	88
Bristol City, VA	15,984	15,978	26	26	16	26
Service Area Total	**648,649**	**651,627**	**1,070**	**1,075**	**650**	**1,050**

Based on these projections, the applicant proposes to care for 650 patients in Year 1 and 1,050 in Year 2.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

- All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)
- The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.
- The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
- For projects that include new construction, modification, and/or renovation; **documentation must be** provided from a contractor and/or architect that support the estimated construction costs.

RESPONSE:

The project costs associated with this proposal are identified in the Project Costs Chart below. Attachment C1 contains documentation support from an architect. Regarding the lease cost, a comparison was completed of the fair market value of the property utilizing the Washington County tax appraisal for the property of $1,215,000. Given the entire building is 11,761 square feet, this calculates to a value of $103.31 per square foot. When this applied to the square footage of the proposed project of 7,851, this equates to a fair market value of $811,067. This is less than the annualized cost of the lease over the 10-year life of the lease which is $1,031,595; the higher of the two was utilized for the facility acquisition costs.

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	$ 32,436
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$ 20,000
3.	Acquisition of Site	$ 0
4.	Preparation of Site	$ 0
5.	Construction Costs	$196,275
6.	Contingency Fund	$ 46,222
7.	Fixed Equipment (Not included in Construction Contract)	$251,050
8.	Moveable Equipment (List all equipment over $50,000)	$166,275
9.	Other (Specify) _____	$ 0
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	$1,031,595
2.	Building only	$ 0
3.	Land only	$ 0
4.	Equipment (Specify)_____	$ 0
5.	Other (Specify) _____	$ 0
C.	Financing Costs and Fees:	
1.	Interim Financing	$ 0
2.	Underwriting Costs	$ 0
3.	Reserve for One Year's Debt Service	$ 0
4.	Other (Specify) _____	$ 0
D.	Estimated Project Cost (A+B+C)	**$1,743,853**
E.	CON Filing Fee	$ 3,924
F.	Total Estimated Project Cost (D+E)	
	TOTAL	**$1,747,777**

SUPPLEMENTAL #1
May 25, 2016
10:45 a.m.

2. Identify the funding sources for this project.

Please check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

__ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

__ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

__ D. Grants--Notification of intent form for grant application or notice of grant award; or

X E. Cash Reserves--Appropriate documentation from Chief Financial Officer.

__ F. Other—Identify and document funding from all other sources.

RESPONSE:
The project will be funded from existing cash reserves from operations at Mountain States Health Alliance. Documentation of the availability of funds to complete the project is provided in Attachment C.2.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

RESPONSE:
The total project cost for this project is $1,747,777. The most recently approved CON for a similar project was the Recovery of Columbia in Maury County, filed in 2009. The total costs of that approved project was $776,251 and construction costs were approximately $10.50 per square foot. This project's construction costs will be $25.00 per square foot.

4. Complete Historical and Projected Data Charts on the following two pages--***Do not modify the Charts provided or submit Chart substitutions!*** Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

RESPONSE:
Given this is a new clinic, there is no historical data. The Projected Data Chart is provided following and profiles the estimated performance for the first two complete fiscal years of operation (FY2018 and FY2019).

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

RESPONSE:

The project's charge per patient information is as follows for Year 2:

Average gross charge per patient:	$3,450
Average deduction from operating revenue (contractual):	$ 207
Average net charge per patient:	$3,243

HISTORICAL DATA CHART

Response: Not Applicable.

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).

	Year____	Year___	*Year*_____
A. Utilization Data (Specify unit of measure)	_____	_____	_____
B. Revenue from Services to Patients			
1. Inpatient Services	$_____	$_____	$_____
2. Outpatient Services	_____	_____	_____
3. Emergency Services	_____	_____	_____
4. Other Operating Revenue (Specify)_____	_____	_____	_____
Gross Operating Revenue	$_____	$_____	$_____
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$_____	$_____	$_____
2. Provision for Charity Care	_____	_____	_____
3. Provisions for Bad Debt	_____	_____	_____
Total Deductions	$_____	$_____	$_____
NET OPERATING REVENUE	$_____	$_____	$_____
D. Operating Expenses			
1. Salaries and Wages	$_____	$_____	$_____
2. Physician's Salaries and Wages	_____	_____	_____
3. Supplies	_____	_____	_____
4. Taxes	_____	_____	_____
5. Depreciation	_____	_____	_____
6. Rent	_____	_____	_____
7. Interest, other than Capital	_____	_____	_____
8. Other Expenses (Specify) _____	_____	_____	_____
Total Operating Expenses	$_____	$_____	$_____
E. Other Revenue (Expenses) – Net (Specify)	$_____	$_____	$_____
NET OPERATING INCOME (LOSS)	$_____	$_____	$_____
F. Capital Expenditures			
1. Retirement of Principal	$_____	$_____	$_____
2. Interest	_____	_____	_____
Total Capital Expenditures	$_____	$_____	$_____
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$_____	$_____	$_____

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The calendar year begins in July (Month).

		Year FY2018	Year FY2019
A.	Utilization Data (Patients)	650	1,050
B.	Revenue from Services to Patients		
1	Inpatient Services	$ -	$ -
2	Outpatient Services	$1,560,000	$3,622,500
3	Emergency Services	$ -	$ -
4	Other Operating Revenue (Specify)_____	$ -	$ -
	Gross Operating Revenue	**$1,560,000**	**$3,622,500**
C.	Deductions for Operating Revenue		
1	Contractual Adjustments	$ -	$ -
2	Provision for Charity Care	$ 78,000	$ 181,125
3	Provisions for Bad Debt	$ 15,600	$ 36,225
	Total Deductions	**$ 93,600**	**$ 217,350**
NET OPERATING REVENUE		**$1,466,400**	**$3,405,150**
D.	Operating Expenses		
1	Salaries and Wages	$ 894,260	$ 986,980
2	Physician's Salaries and Wages	$ 308,050	$ 616,100
3	Supplies	$ 143,000	$ 262,500
4	Taxes	$ -	$ -
5	Depreciation	$ 60,816	$ 60,816
6	Rent	$ 94,212	$ 96,096
7	Interest, other than Capital	$ -	$ -
8	Management Fees		
	a. Fees to Affiliates	$ 93,600	$ 217,350
	b. Fees to Non-Affiliates	$ -	$ -
9	Other Expenses (Specify on Next Page)	$ 198,883	$ 208,883
	Total Operating Expenses	**$1,792,821**	**$2,448,725**
E.	Other Revenue (Expenses) -- Net (Specify)	$ -	$ -
NET OPERATING INCOME (LOSS)		**$ (326,421)**	**$ 956,425**
F.	Capital Expenditures		
1	Retirement of Principal	$ -	$ -
2	Interest	$ -	$ -
	Total Capital Expenditures	**$ -**	**$ -**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ (326,421)**	**$ 956,425**

HISTORAL DATA CHART – OTHER EXPENSES

Response: Not Applicable.

OTHER EXPENSES CATEGORIES	Year _____	Year _____	Year _____
1.	$_____	$_____	$_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
Total Other Expenses	$_____	$_____	$_____

PROJECTED DATA CHART – OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year FY2018	Year FY2019
1. Common Area Maintenance, Insurance, Real Estate Taxes	$ 35,330	$ 35,330
2. Consulting	$ 50,000	$ 0
3. Utilities, Janitorial	$ 23,553	$ 23,553
4. Security	$ 80,000	$ 80,000
5. CARF Accreditation	$ 0	$ 10,000
6. Marketing	$ 0	$ 10,000
7. Other	$ 10,000	$ 50,000
Total Other Expenses	**$ 198,883**	**$ 208,883**

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

RESPONSE:
As this is not an existing facility, there are currently no charges for revenues from existing charges. Patients will be charged approximately $13 per day for treatment. This will be inclusive of the medication, counseling, case management/social work services, testing and so forth. The projected revenues in the first year of operations are $1,560,000. The proposed OTP will be located in an area without any existing providers therefore there will be no impact on existing charges.

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

RESPONSE:
There are no OTPs in the proposed service area, but the applicant did survey Behavioral Health Group (BHG), which operates 10 of the 12 clinics that exist in Tennessee. BHG has clinics located in Memphis, Dyersburg, Jackson, Paris, Columbia, Nashville, and Knoxville. According to this survey, they noted their total 30-day with medication cost ranges from $430 to $460, which equates to approximately $14 to $15 per day for treatment. The proposed OTP plans to charge approximately $13 per day for treatment.

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

RESPONSE:
The proposed project will have a positive net income by Year 2 without increasing its charges.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

RESPONSE:
Revenue and expense information for this proposal for Years 1 and 2 following project completion is included in the Projected Data Chart. The net income is projected to be ($326,421) and $952,425 in years 1 and 2, respectively. Any positive income will be reinvested back into the larger Center after MSHA's initial capital expenses are covered. The reinvestments will be earmarked for ongoing research and evaluation to identify additional evidence-based approaches that will be effective across the continuum of addiction. MSHA has the resources to cover the first year of losses.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

RESPONSE:
The intent behind this proposed project is to meet the needs of the community and the region. This is a unique endeavor which involves the joint undertaking by ETSU and MSHA to create a not-for-profit OTP. To the best of the applicant's knowledge none of the existing 12 OTPs in the state accept Medicare or TennCare/Medicaid. This proposed OTP, if approved, will diligently pursue coverage for treatments to Medicare and TennCare patients.

While the coverage of medication-assisted therapy by Medicare is complicated, the applicant intends to accept Medicare to the extent possible. Medicare does not appear to cover methadone when provided in an outpatient clinic nor do Part D plans cover methadone to treat substance abuse (only for pain). Initial research indicates that buprenorphine treatment costs are typically not covered by Medicare unless the treatment is provided in an inpatient or outpatient treatment center. It may also be covered in some instances, such as during detoxification or early stage stabilization. However, the Medicare benefit does not usually cover typical office-based buprenorphine induction or maintenance treatment visits.

In some instances, Medicare Part D may cover the cost of the buprenorphine tablets themselves. Only some Medicare providers will reimburse (including Healthnet Orange, Silverscript, and Wellcare) and prior authorization is usually required.

Regarding TennCare, it will cover methadone for only a very limited population, those enrollees who are 18 to 20 years of age. Given the unique mission of this proposed OTP, the applicant plans to explore opportunities with TennCare to contract directly to meet the needs of a broader age span for both methadone and buprenorphine.

While it is the applicant's intention to fully explore options for the participation in Medicare and TennCare for both buprenorphine and methadone, given the uncertainty regarding the extent to which the applicant will be successful, it is not possible to quantify the number of patients who may be covered by those programs. Therefore, the proposed payor mix does not include any Medicare or TennCare/Medicaid.

The applicant did project five percent of revenues will be from charity care patients who meet established eligibility requirements. This equates to approximately $78,000 in year 1 and $181,125 in year 2 for charity care.

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

RESPONSE:
This is a newly formed nonprofit corporation that will have MSHA and the ETSU Research Foundation as its members. The most recent reporting period audited balance sheets and income statements for Mountain States Health Alliance are located in Attachment C.10 (audited statements for Fiscal Year 2014 and 2015). The most recent financial audit report for the ETSU Research Foundation is also located in Attachment C.10 (audited statements for Fiscal Year 2014 and 2015).

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

    a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

    RESPONSE:
    One alternative to the proposed project is to maintain status quo. The applicant does not believe this is a viable option given the breadth and severity of opioid addiction in the region. Without any clinically valid treatment options that are coupled with comprehensive wrap-around services including extensive counseling and therapy as well as care management resources (such as support for social needs such employment placement, housing, and so forth) all provided utilizing various evidence-based approaches that work at different points along the continuum of addiction, this problem will only continue to reach epidemic portions.

    Another alternative is for the state to approve an OTP owned by an out-of-state for-profit enterprise. This option does not offer the unique opportunity for local collaboration to address a local epidemic. The proposed project represents an innovative model to bring ETSU's academic health sciences education and research resources together with the operational expertise of local area providers (including MSHA and Frontier Health). This model will be based on treatment options across the continuum of addiction; the OTP is only one component of a larger Center focused intently on research, education, prevention, and outreach aimed at combating one of the most devastating and wide-reaching challenges in the community. This is the only model the applicant is aware of in which the net proceeds will be reinvested into the Center for ongoing research and evaluation to identify additional evidence-based approaches that will be effective across the continuum of addiction.

    b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

    RESPONSE:
    Not applicable as there is no new construction associated with the proposed project.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

    RESPONSE:
    As the managing entity of the proposed project, Mountain States Health Alliance will continue to work closely with other healthcare providers in the region, including: Mountain States Health Alliance hospitals, East Tennessee State University and the James H. Quillen College of Medicine, local nursing homes, clinics and other healthcare providers. MSHA already has existing transfer agreements with other area hospitals including those apart of the Wellmont Health System as well as Laughlin Memorial Hospital as examples.

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

RESPONSE:
There are currently no other non-residential methadone clinics in the proposed service area. TDMHSAS notes there are currently 12 licensed clinics in TN with the nearest two both located in Knoxville. The proposed project represents an innovative opportunity to increase access to this much needed clinical option, but it also is part of a larger Center providing a more effective system of care to address the prescription drug epidemic.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

RESPONSE:
The proposed OTP will adhere to the Personnel and Staffing Requirements of the Rules of the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). As such, the proposed program will have a program director, a medical director, a program physician, nurses, and counselors. These positions will meet all the staff qualifications as outlined by TDMHSAS.

The following table profiles the Year 2 FTE count by position, projected staff salaries, and salary comparisons (from the 2016 Tennessee Hospital Association Salary Survey). Following this table is a listing of the various staff positions and their roles within the certified OTP.

Position	FTE	Annual Salary per FTE	Salary Comparison (50th Percentile)
Medical Director	1.0	$225,000	N/A
On-Site Prescriber	2.0	$140,000	N/A
Nurses – RNs (1 lead, 1 dosing)	2.0	$50,000	$53,000
Nurses – LPNs (dosing)	2.0	$40,000	$41,000
Therapist (LCSW)	1.0	$85,000	N/A
Therapists (Unlicensed)	4.0	$36,000	$39,500
Clinical Pharmacist	1.0	$135,000	$122,000
Psychiatric Nurse Practitioner	1.0	$95,000	$102,000
Program Director, Operations	1.0	$80,000	N/A
Office Manager	1.0	$45,000	$41,200
Billing/Scheduling Manager	1.0	$45,000	$31,000

Source: 2016, THA Salary Survey, 50th Percentile provided.

- **Program Director, Operations:** This position will be responsible for the operation of the Facility and overall compliance with federal, state and local laws and regulations regarding the operation of opioid treatment programs, and for all employees including practitioners, agents, or other persons providing services at the Facility.
- **Medical Director:** This position will be responsible for the administration of all medical services, including compliance with all federal, state and local laws and regulations

regarding the medical treatment of opioid addiction. The medical director shall be licensed to practice medicine or osteopathy in Tennessee, shall maintain their licenses in good standing and shall have the following experience and/or credentials:

1. Three years of documented experience in the provision of services to persons who are addicted to alcohol or other drugs, including at least one year of experience in the treatment of opioid addiction;
2. Board eligibility in psychiatry and two years of documented experience in the treatment of persons who are addicted to alcohol or other drugs; or
3. Certification as an addiction medicine specialist by the American Society of Addiction Medicine (ASAM) or Board certification as an addiction medicine specialist.

- **Program Physician/Prescriber:** This position will provide the medical treatment and oversight necessary to serve service recipient needs. All physicians shall be licensed to practice medicine in Tennessee, shall maintain their licenses in good standing and shall have at least one year of documented experience in the treatment of persons addicted to alcohol or other drugs. Will oversee nurses, nurse practitioners and physician assistants and prescribe medically assisted therapy.
    1. Physician services include, but are not limited to, performing medical history and physical exams, determining a diagnosis under current DSM criteria, determination of opioid dependence, ordering take-home privileges, discussing cases with the treatment team and issuing any emergency orders.
    2. Will provide, at a minimum, on-site prescriber services of one hour per week for every 35 service recipients. Will provide, at a minimum, 12.5 percent of the required prescriber services per week.
- **Nurses** This position will ensure that adequate nursing care is provided at all times the Facility is in operation and be present at all times medication is administered. Nurses will direct clinical care and duties may include prescribing with supervision, charting, notes and facilitation of research and administration. All registered nurses and licensed practical nurses shall be licensed to practice in Tennessee and shall maintain their license in good standing. The proposed OTP will hire one lead registered nurse, one dosing registered nurse and two dosing licensed practical nurses.
- **Counselor/Therapist:** There shall be sufficient group and individual counseling available to meet the needs of the service recipient population. All counselors shall be qualified by training, education and/or two years' experience in addiction treatment under appropriate clinical supervision in order to provide addiction counseling services. Any unlicensed counselors will complete the process of obtaining appropriate licensure and/or certification. The proposed OTP will hire one Licensed Professional Counselor to be the lead and provide oversight of the therapy program, program plan, and provide specialized care to individuals in need. This position will oversee three unlicensed, master of social work prepared counselors.
- **Office Manager:** Responsibilities will include scheduling clinicians, overseeing and supervising office staff, assuring compliance with HIPAA and that all HIPAA training is complete and up to date. This position and the billing and scheduling manager will report to the program director of operations.
- **Clinical Pharmacist:** This position will direct clinical care provision and provide medication management for the clinic. They will need to be thoroughly trained in the examination of psychopharmacology associated with drugs of abuse. They will be responsible for completing charting, follow-up and facilitating research and evaluation activities and projects.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of

Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

RESPONSE:
Just as ETSU and MSHA recruit and retain staff by offering salary and benefit packages appropriate for the market, the applicant will do the same if approved. The proposed OTP will adhere to the Personnel and Staffing Requirements of the Rules of the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). As such, the proposed program will have a program director, a medical director, a program physician, nurses, and counselors. These positions, coupled with the ones noted in the prior chart will meet all the staff qualifications as outlined by TDMHSAS. The proposed staffing is more extensive than typically observed by other existing OTPs in the state, as it will include one licensed clinical social worker and four masters level social workers to provide an elevated level of therapy and case management type services.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.

RESPONSE:
The applicant has reviewed and understands all licensing certifications as required by the State of Tennessee. If approved, policies and procedures will be put in place governing regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.,* internships, residencies, etc.).

RESPONSE:
The applicant's members, Mountain States Health Alliance and East Tennessee State University work extensively together to train students; student education is in fact at the very core of ETSU's mission and statement of purpose which is provided below.

East Tennessee State University prepares students to become productive, enlightened citizens who actively serve their communities and the world. Education is the university's highest priority, and the institution is committed to increasing the level of educational attainment in the state and region. The university conducts a wide array of educational and research programs and clinical services and is the only Academic Health Sciences Center in the Tennessee Board of Regents System. Through research, creative activity and public service ETSU advances the cultural, intellectual and economic development of the region and the world.

- ETSU endorses the value of liberal education and provides enriching experiences in honors education, student research and creative activity, study abroad, service learning, and community-based education.
- ETSU honors and preserves the rich heritage of Southern Appalachia through distinctive education, research and service programs and is actively engaged in regional stewardship.

- ETSU affirms the contributions of diverse people, cultures and thought to intellectual, social and economic development.
- ETSU offers students a total university experience that includes cultural and artistic programs, diverse student activities, a variety of residential opportunities, and outstanding recreational and intercollegiate athletic programs.
- ETSU awards degrees in over one hundred baccalaureate, masters and doctoral programs, including distinctive interdisciplinary programs and distance education offerings that serve students from the region and beyond. (approved by the Tennessee Board of Regents 5/28/2014)

MSHA is affiliated with the James H. Quillen College of Medicine at ETSU, located in Johnson City, Tennessee. MSHA also works with other area colleges and universities and has the largest number of medical residents in the Tri-Cities area. While this will not be part of the initial staffing, the proposed program does plan to incorporate students and interns for training purposes. This could range from nursing students, social work interns, and counseling students which are all existing programs available at ETSU.

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

RESPONSE:
The proposed project will comply as applicable with licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and any applicable Medicare requirements.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

RESPONSE:
Licensure:

If approved, the applicant will seek licensure from the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) and the U.S. Department of Justice, Drug Enforcement Agency.

Accreditation:

If approved, the applicant will seek accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF).

Certification:

If approved, the applicant will seek certification as an Opioid Treatment Program (OTP) by the Substance Abuse and Mental Health Services Administration (SAMHSA).

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

RESPONSE:
Not applicable as this is a new OTP being requested.

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

RESPONSE:
Not applicable as this is a new OTP being requested.

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

RESPONSE:
There are no final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project

RESPONSE:
There are no final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

RESPONSE:
The applicant will, if approved, provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated the number and type of procedures performed, and other data as requested.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Please note that Tennessee Code Annotated 68-11-1607(c)(3) states that "...Within ten (10) days of filing an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the member of the House of Representatives and the Senator of the General Assembly representing the district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution based treatment center for opiate addiction has been filed with the agency by the applicant."

Please provide this documentation.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): 08/24/2016

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase		DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1.	Architectural and engineering contract signed	15	9/8/2016
2.	Construction documents approved by the Tennessee Department of Health	21	9/29/2016
3.	Construction contract signed	15	10/14/2016
4.	Building permit secured	14	10/28/2016
5.	Site preparation completed	90	2/2/2017
6.	Building construction commenced	7	11/4/2016
7.	Construction 40% complete	32	12/6/2016
8.	Construction 80% complete	30	1/5/2017
9.	Construction 100% complete (approved for occupancy)	30	2/4/2017
10.	*Issuance of license	3	2/7/2017
11.	*Initiation of service	7	2/14/2017
12.	Final Architectural Certification of Payment	7	2/21/2017
13.	Final Project Report Form (HF0055)	14	3/7/2017

*** For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

East Tennessee Healthcare Holdings, Inc.
Non-residential Opioid Treatment Program Project
Certificate of Need Application Attachments

Attachment A.3: Corporate Charter and Certificate of Corporate Existence

Attachment A.4: Organizational Structure and List of Health Care Institutions

Attachment A.5: Draft Management Agreement

Attachment A.6: Title / Deed / Legal Interest in Site and Commitment to Lease

Attachment B.III.(A) & B.IV: Plot Plan & Floor Plans

Attachment C, Need 1: Service Area Maps

Attachment C, Need 2: Map and List of Existing Providers

Attachment C, Need 3: National Map of Drug Poisoning Related Deaths

Attachment C, Need 4: Drive Time Assessment

Attachment C, Need 5: Service Area Demographic Snapshot

Attachment C, Economic Feasibility 1: Construction Costs Documentation

Attachment C, Economic Feasibility 2: Letter of Available Funds

Attachment C, Economic Feasibility 10: Most Recent Audited Statements – FY2014 and FY2015 for Mountain States Health Alliance and ESTU Research Foundation

Attachment C, Proof of Publication: Publication of Intent, Johnson City Press

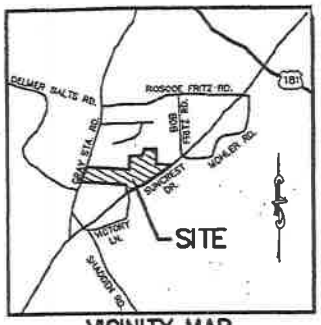
Attachment C, Notification: Notification of Project to Local Officials

Attachment: Affidavit for Application

ATTACHMENT B.III. (A) & B.IV.

1. Plot Plan
2. Floor Plans

GRAY COMMONS SUBDIVISION
PROPERTY EXHIBIT



VICINITY MAP
N.T.S.

NOTE :
THIS DRAWING IS A COMBINATION OF PLATS, DRAWINGS, AND GRADING PLANS AND IS NOT A FIELD RUN SURVEY. IT SHOULD NOT BE USED FOR TRANSFER OF PROPERTY OR DESIGN.

JESSE JENKINS II
D.B. 233–PG. 3

JESSE JENKINS II
D.B. 650–PG. 586

0.071 Ac± TO BE DEDICATED TO CITY OF JOHNSON CITY FOR SANITARY SEWER PUMP STATION

DOLPH BREWER
D.B. 646–PG. 406

GRAY STATION LAND CO.
D.B. 498–PG. 559

CLYDE DEVAULT
D.B. 646–PG. 459
D.B. 623–PG. 250

82

GRAY STATION SULPHER SPRINGS ROAD

GRAY COMMONS CIRCLE

SUNCREST DRIVE

60'

25'±

6 — 6.075 Ac±
5 — 4.355 Ac±
4 — 1.754 Ac±
3 — 2.029 Ac±
2 — 2.103 Ac±
1 — BUILDING
7A — 4.360 Ac±
7 — BUILDING
8 — 13.093 Ac±

KYLE HARRISON
D.B. 399–PG. 593

HAROLD WALKER
R. 69–I. 456

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(423) 854–4563 FAX
thp@tysinger–engineering.com
http://www.tysinger–engineering.com

GRAPHIC SCALE

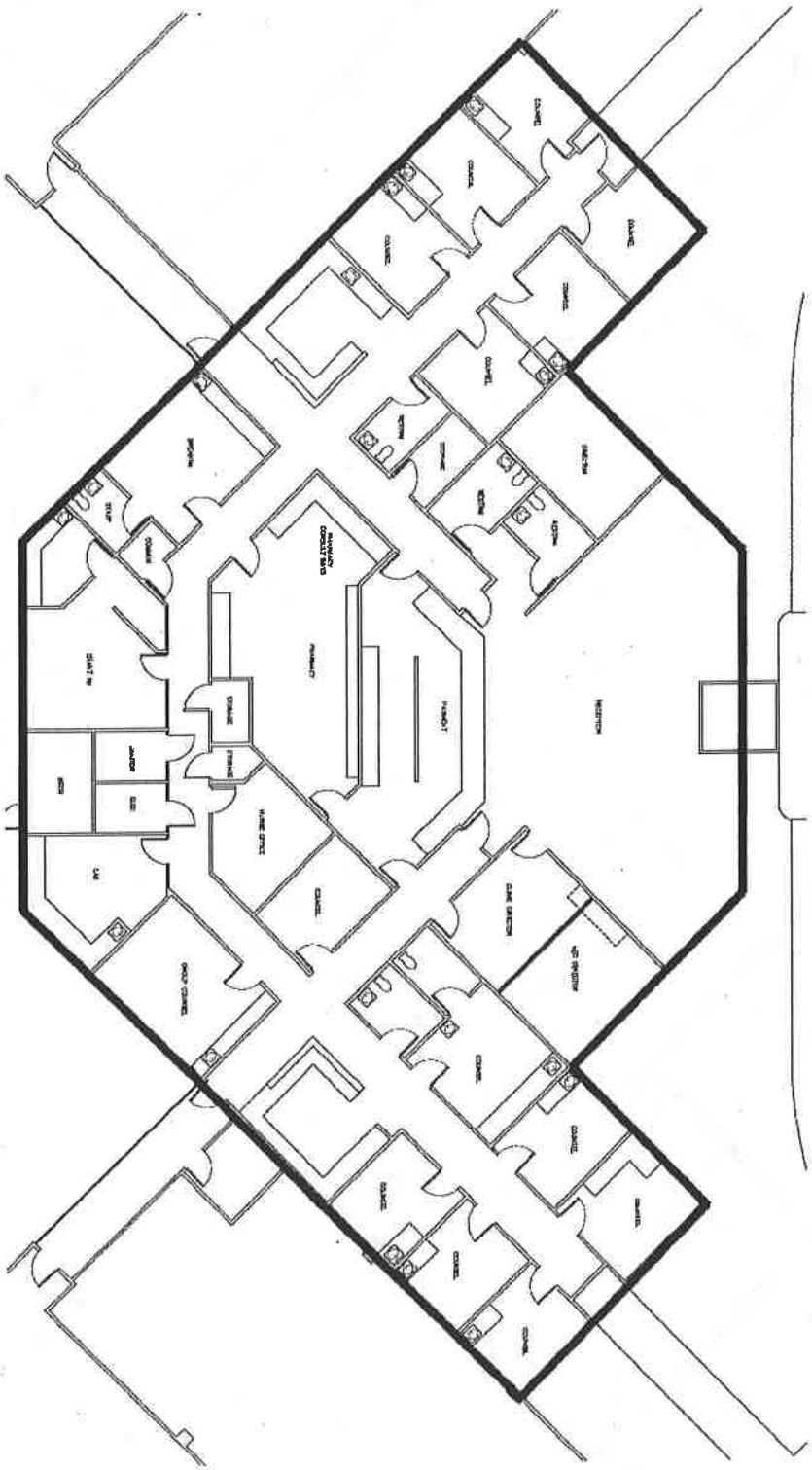
200 0 100 200 400 800

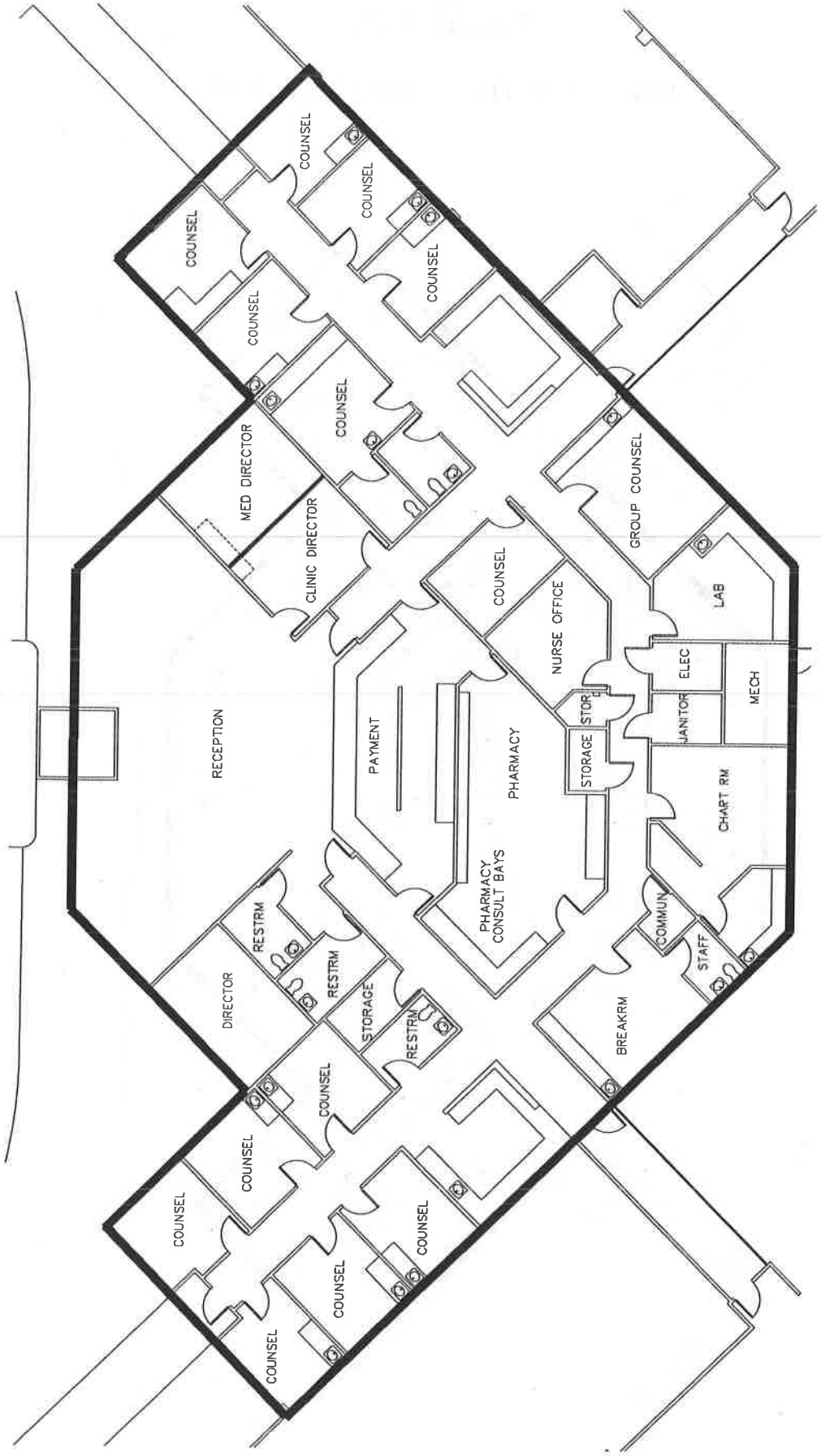
(IN FEET)
1 inch = 200 ft.

CAD FILE : 0231300s–gray–commons.dwg

Exhibit A

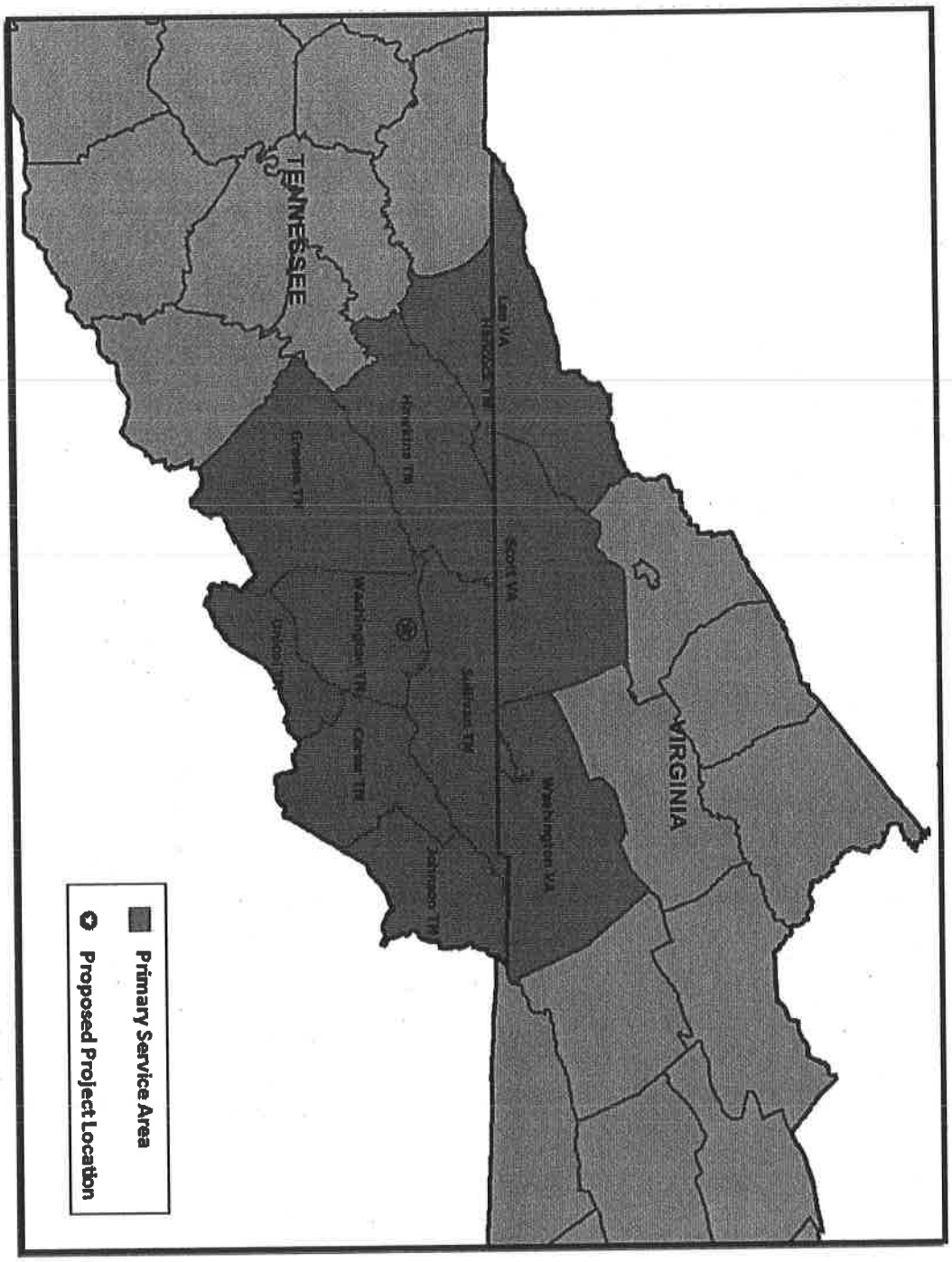
Proposed Floor Plan for Suite 110 (7,851 SF)

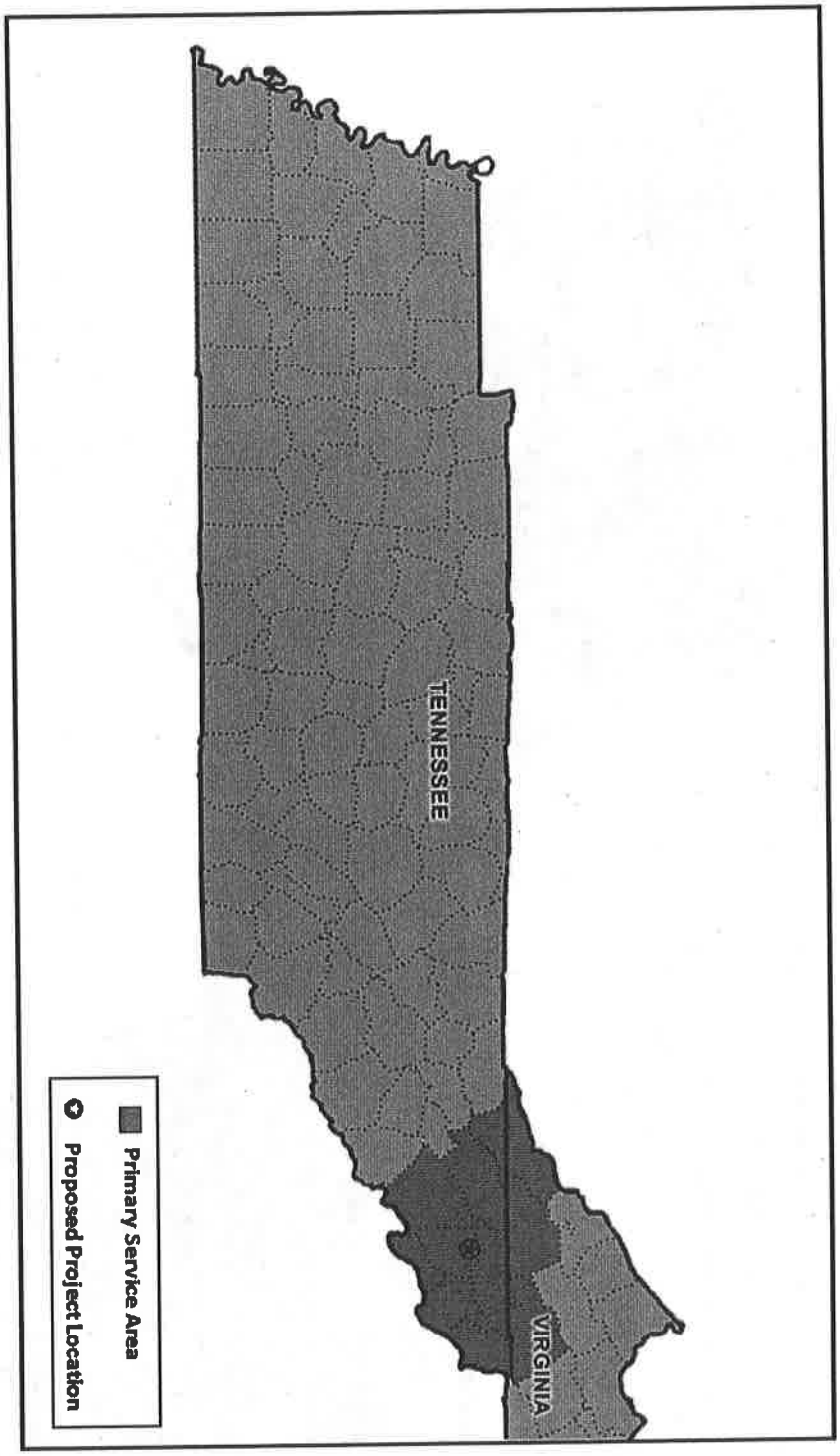


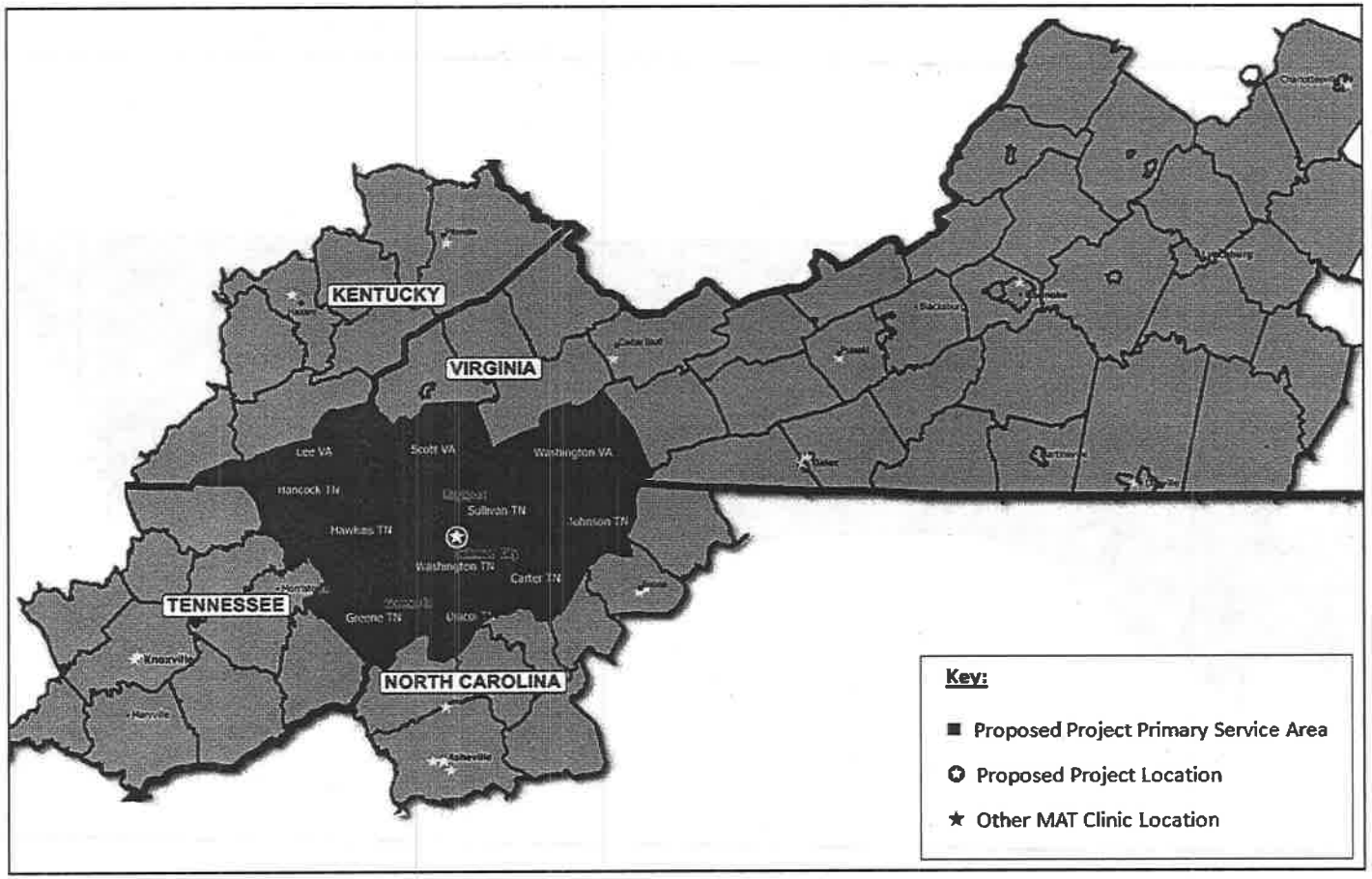

COUNSEL
COUNSEL
COUNSEL
COUNSEL
COUNSEL
COUNSEL
MED DIRECTOR
CLINIC DIRECTOR
COUNSEL
GROUP COUNSEL
COUNSEL
NURSE OFFICE
LAB
ELEC
MECH
JANITOR
STOR
STORAGE
RECEPTION
PAYMENT
PHARMACY
CHART RM
PHARMACY CONSULT BAYS
COMMUN
STAFF
RESTRM
RESTRM
RESTRM
STORAGE
DIRECTOR
BREAKRM
COUNSEL
COUNSEL
COUNSEL
COUNSEL
COUNSEL
COUNSEL

ATTACHMENT C, NEED (1)

Service Area Maps


TENNESSEE
VIRGINIA
Primary Service Area
Proposed Project Location

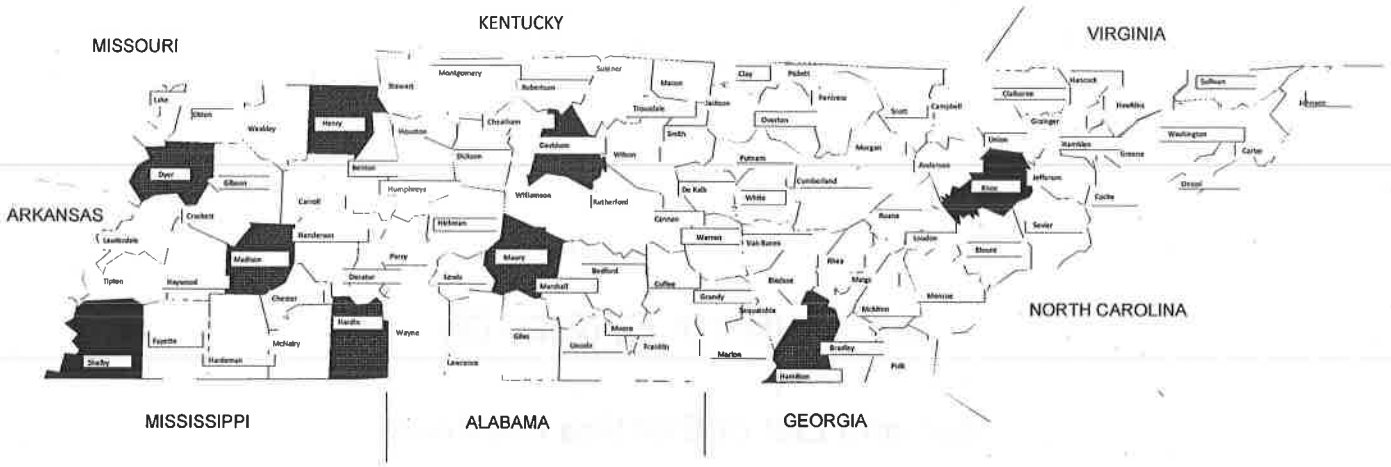

TENNESSEE
VIRGINIA
Primary Service Area
Proposed Project Location


KENTUCKY
VIRGINIA
TENNESSEE
NORTH CAROLINA
Lee VA
Scott VA
Washington VA
Hancock TN
Sullivan TN
Johnson TN
Hawkins TN
Washington TN
Carter TN
Greene TN
Unicoi TN
Knoxville
Asheville
Key:
Proposed Project Primary Service Area
Proposed Project Location
Other MAT Clinic Location

ATTACHMENT C, NEED (2)

Map and List of Existing Providers

Tennessee Opioid Treatment Clinics



● ONE LOCATION ● TWO LOCATIONS ● THREE LOCATIONS

Shelby (Memphis)
BHG Memphis South Treatment Center
(901) 375-1050

BHG Memphis Midtown Treatment Center
(901) 722-9420

BHG Memphis North Treatment Center
(901) 372-7878

Dyer (Dyersburg)
BHG Dyersburg Treatment Center
(732) 285-6535

Madison (Jackson)
BHG Jackson Treatment Center
(731) 660-0880

Henry (Paris)
BHG Paris Treatment Center
(731) 641-4545

Hardin (Savannah)
Solutions of Savannah
(731) 925-2767

Maury (Columbia)
BHG Columbia
(931) 381-0020

Davidson (Nashville)
BHG Nashville Treatment Center
(615) 321-2575

Hamilton (Chattanooga)
Volunteer Treatment Center, Inc.
(423) 265-3122

Knox (Knoxville)
BHG Knoxville Citico Treatment Center
(865) 522-0661

BHG Knoxville Bernard Treatment Center
(865) 522-0161

Physicians authorized to treat opiod dependency with buprenorphine

Source: http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator

	First	Last	Deg.	Address	City	County	State	Zip	Tele.	Fax
Dr.	Bruce	Boggs	M.D.	203 Gray Commons Circle	Gray	Washington	Tennessee	37615	(423) 477-0600	(423) 245-9634
Dr.	Mark	Ernest	M.D.	516 W. Oakland Ave. Suite 106	Johnson City	Washington	Tennessee	37604	(423) 722-3100	(423) 722-3104
Dr.	Aubrey	McElroy	Jr.	3201 Bristol Highway Suite 4	Johnson City	Washington	Tennessee	37601	(423) 262-8132	(423) 262-8139
Dr.	Matthew	Gangwer	M.D.	401 East Main Street Suite 3	Johnson City	Washington	Tennessee	37601	(706) 244-1390	(423) 232-0223
Dr.	David	Forester	M.D.	209 East Unaka Avenue	Johnson City	Washington	Tennessee	37601	(423) 434-4677	(423) 434-4645
Dr.	Michael	Wysor	M.D.	Medical Care Walk In Clinic 105 Broyles Drive, Suite B	Johnson City	Washington	Tennessee	37601	(423) 722-4000	(423) 722-4004
Dr.	Laura	Grobovsky	M.D.	501 East Watauga Avenue	Johnson City	Washington	Tennessee	37601	(423) 722-8446	(423) 722-5674
Dr.	Frank	Stump	M.D.	Doctor's Assisted Wellness 2406 Susannah Street	Johnson City	Washington	Tennessee	37601	(423) 928-1393	
Dr.	Edward	Crutchfield	M.D.	500 E. Unaka Ave	Johnson City	Washington	Tennessee	37601	(423) 631-0783	(423) 631-0786
Dr.	Gregg	Kesterson	M.D.	105 Broyles DriveSuite B	Johnson City	Washington	Tennessee	37601	(865) 310-4741	(865) 470-2633
Dr.	Martin	Eason	M.D.	926 West Oakland Avenue, Suite 222	Johnson City	Washington	Tennessee	37604	(423) 282-3379	(423) 631-0732
Dr.	Stephen	Loyd	M.D.	205 High Point Drive	Johnson City	Washington	Tennessee	37601	(423) 631-0732	(423) 631-0732
Dr.	Christine	Carrejo	M.D.	Watauga Family Practice 501 East Watauga Avenue	Johnson City	Washington	Tennessee	37601	(423) 722-8446	(423) 722-5674
Dr.	Cynthia	Partain	M.D.	401 East Main Street	Johnson City	Washington	Tennessee	37601	(423) 929-2584	(423) 538-2584
Dr.	Stephen	Cirelli	M.D.	Medical Care Clinic 105 Broyles Drive	Johnson City	Washington	Tennessee	37601	(423) 722-4000	(423) 722-4004
Dr.	Michael	Tino	M.D.	Doctors Assisted Wellness & Recovery 2406 Susannah Street	Johnson City	Washington	Tennessee	37601	(423) 928-1393	(423) 928-1392
Dr.	Cyrus	Erickson	M.D.	105 Broyles Drive Suite B	Johnson City	Washington	Tennessee	37601	(423) 722-4000	(423) 722-4004
Dr.	Hemang	Naik		2406 Susannah St	Johnson City	Washington	Tennessee	37601	(423) 928-1393	(423) 928-1392
Dr.	Millard	Lamb	M.D.	Recovery Associates Inc. of Tennessee 401 East Main Street	Johnson City	Washington	Tennessee	37601	(423) 232-0222	
Dr.	Ray	Mettetal	Jr., M.D.	3201 Bristol Highway Suite 4	Johnson City	Washington	Tennessee	37601	(423) 282-5951	(423) 262-8139
Dr.	Dana	Brown		501 East Watauga Avenue	Johnson City	Washington	Tennessee	37601	(423) 722-8446	(423) 722-5674
Dr.	Elli	Saraceno	M.D.	205 High Point Drive	Johnson City	Washington	Tennessee	37601	(423) 631-0731	(423) 631-0732
Dr.	Charles	Backus	III	Morgan Counseling Services 412 West Unaka Street	Johnson City	Washington	Tennessee	37604	(423) 833-5547	
Dr.	Edgar	Ongtengco	M.D.	2514 Wesley Street Suite 101	Johnson City	Washington	Tennessee	37604	(423) 833-5547	(423) 232-0238
Dr.	Richard	Bowie	M.D.	Watauga Recovery Center 3114 Browns Mill Road	Johnson City	Washington	Tennessee	37604	(423) 631-0432	
Dr.	Jason	Della Vecchia	M.D.	Restoration & Wellness 110 Corporate Drive, Suite 100	Johnson City	Washington	Tennessee	37604	(423) 434-6677	(423) 434-6678
Dr.	Hetal	Brahmbhatt	M.D.	500 Longview Drive	Johnson City	Washington	Tennessee	37604	(423) 975-5444	(423) 767-5444
Dr.	Navneet	Gupta	M.D.	101 Med Tech Parkway Suite 200	Johnson City	Washington	Tennessee	37604	(423) 232-6120	(423) 232-6125
Dr.	James	Denham	M.D.	1747 Skyline Drive Unit 25	Johnson City	Washington	Tennessee	37604	(901) 210-5079	
Dr.	Matthew	Thomas	D.O.	Watauga Recovery Center 311 Brown's Mill Road	Johnson City	Washington	Tennessee	37604	(423) 631-0432	(423) 631-0284
Dr.	Atif	Rasheed	M.D.	3114 Browns Mill Road	Johnson City	Washington	Tennessee	37604	(423) 631-0432	
Dr.	Ralph	Reach		3114 Browns Mill Road	Johnson City	Washington	Tennessee	37604	(423) 631-0432	(423) 631-0272
Dr.	Jack	Woodside	Jr., M.D.	917 West Walnut Street	Johnson City	Washington	Tennessee	37604	(423) 439-6464	(423) 439-4320
Dr.	John	Argerson	M.D.	926 West Oakland Avenue Suite 222	Johnson City	Washington	Tennessee	37604	(423) 282-3379	
Dr.	Zachary	Hammons	M.D.	Catalyst Health Solutions, LLC 926 West Oakland Avenue, Suite 222	Johnson City	Washington	Tennessee	37604	(423) 282-3379	(423) 282-8142
Dr.	Juan	Rodriguez	M.D.	110 Corporate Drive Suite 110	Johnson City	Washington	Tennessee	37604	(423) 943-2491	
Dr.	Jaclyn	Newman	M.D.	826 Polk Avenue	Johnson City	Washington	Tennessee	37604	(423) 929-2854	
Dr.	Coleen	Smith	D.O.	205 High Point Drive	Johnson City	Washington	Tennessee	37604	(423) 631-0731	(423) 631-0732
Dr.	John	Miller	M.D.	811 Wedgewood Road	Johnson City	Washington	Tennessee	37604	(423) 282-5381	(423) 262-8382
Dr.	Rakesh	Patel	M.D.	403 North State of Franklin Road	Johnson City	Washington	Tennessee	37604	(423) 979-0565	(423) 915-5115
Dr.	Kimberly	Roller	M.D.	3114 Browns Mill Road	Johnson City	Washington	Tennessee	37604	(423) 631-0432	(423) 631-0284
Dr.	Cody	Davis	D.O.	2406 Susannah Street	Johnson City	Washington	Tennessee	37604	(423) 928-1393	(423) 928-1392
Dr.	Marianne	Filka	M.D.	Watauga Recovery Center 3114 Browns Mill Road	Johnson City	Washington	Tennessee	37604	(423) 631-0432	(423) 631-0284
Dr.	Timothy	Smyth	M.D.	Catalyst Health Solutions 926 West Oakland Avenue, Suite 222	Johnson City	Washington	Tennessee	37604	(423) 282-3379	(423) 282-8142
Dr.	Craig	Haire	M.D.	3114 Browns Mill Road	Johnson City	Washington	Tennessee	37604	(423) 631-0432	(423) 631-0284
Dr.	William	Kyle	D.O.	3114 Browns Mill Road	Johnson City	Washington	Tennessee	37604	(423) 631-0272	
Dr.	LeRoy	Osborne	D.O.	Morgan Counseling & Accociates 214 West Unaka Avenue	Johnson City	Washington	Tennessee	37604	(423) 676-9015	(423) 926-5246

Dr.	Robert	Reeves	M.D.	926 West Oakland Avenue Suite 222	Johnson City	Washington	Tennessee	37604	(423) 282-3379	(423) 282-8142
Dr.	Sonya	Saadati	D.O.	926 West Oakland Avenue Suite 222	Johnson City	Washington	Tennessee	37604	(423) 282-3379	(423) 217-0699
Dr.	Donald	Sleeter	M.D.	3114 Browns Mill Road	Johnson City	Washington	Tennessee	37604	(423) 631-0432	(423) 631-0284
Dr.	Zia Ur	Rahman	M.D.	1098 Charter Row	Johnson city	Washington	Tennessee	37604	(423) 440-5135	
Dr.	Joseph	Pinyard	Jr., M.D.	516 W Oakland Ave Suite 106	Johnson City	Washington	Tennessee	37604	(423) 772-3100	(423) 772-3104
Dr.	Octavio	Pinell	M.D.	Catalyst Health Solutions 926 West Oakland Avenue	Johnson City	Washington	Tennessee	37604	(423) 282-3379	(423) 282-8124
Dr.	Donald	Henson	Jr. M.D.	James H. Quillen VA Medical Center Dept. of Psych., 116-A, P.O. Box 4000	Mountain Home	Washington	Tennessee	37684	(423) 926-1171x2765	(423) 979-3616
Dr.	Kevin	Rowe	D.O.	1 Lake Drive	Mountain Home	Washington	Tennessee	37684	(608) 334-5882	(423) 439-2210
Dr.	David	Forester	M.D.	James H. Quillen VA Medical Center P.O. Box 4000 116A	Mountain Home	Washington	Tennessee	37684	(423) 926-1171x7150	(423) 979-3616
Dr.	Darin	Hale	M.D.	2412 Susannah Street Suite 2	Johnson City	Washington	Tennessee	37601	(423) 641-1033	(866) 560-9772
Dr.	Joshua	Morris	D.O.	110 Corporate Drive Suite 100	Johnson City	Washington	Tennessee	37604	(423) 434-6677	(423) 434-6678
Dr.	Shannon	Hansen Cook	M.D.	Watauga Recovery Center 3114 Browns Mill Road	Johnson City	Washington	Tennessee	37604	(423) 631-0432	(423) 232-8818
Dr.	Andrew	Brown	M.D.	1019 West Oakland Avenue Suite 1	Johnson City	Washington	Tennessee	37604	(423) 915-5000	(423) 915-5045
Dr.	Shannon	Hansen Cook	M.D.	James H Quillen VA Lamont & Veterans Way	Mountain Home	Washington	Tennessee	37684	(803) 746-7660	(423) 979-3481
Dr.	Marc	Valley	M.D.	411 Princeton Drive Suite 101	Johnson City	Washington	Tennessee	37601	(423) 282-1171	(423) 282-1181
Dr.	Michelle	King	M.D.	518 Carolina Avenue	Erwin	Unicoi	Tennessee	37650	(423) 330-6105	(423) 330-6305
Dr.	Todd	Whitaker	M.D.	3614 Unicoi Drive	Unicoi	Unicoi	Tennessee	37692	(423) 743-7151	(423) 743-3416
Dr.	Daniel	Paul	M.D.	138 Industrial Drive South	Elizabethton	Carter	Tennessee	37643	(423) 542-7007	
Dr.	Scott	Caudle		1503 West Elk Avenue Suite 1	Elizabethton	Carter	Tennessee	37643	(423) 543-8619	(423) 543-5133
Dr.	Edgar	Perry	M.D.	401 HudsonDrive Suite # 3	Elizabethton	Carter	Tennessee	37643	(423) 543-2721	(423) 543-2721
Dr.	Elliott	Smith	Jr.	1406 Tusculum Boulevard, Suite 2003	Greeneville	Greene	Tennessee	37745	(423) 636-0050	(423) 636-0062
Dr.	Tony	Yost	M.D.	206 Easy Street	Greeneville	Greene	Tennessee	37745	(423) 422-2126	(865) 560-7396
Dr.	Kelly	Chumbley	D.O.	Emmaus Medical and Counseling, 45 Laurel Gap Road	Baileyton	Greene	Tennessee	37745	(423) 646-8400	
Dr.	Wayne	Gilbert	M.D.	Trinity Recovery Clinic, 895 East Andrew Johnson Highway	Greeneville	Greene	Tennessee	37745	(423) 639-3330	(423) 639-3342
Dr.	Gregory	Vines		65 Payne Road	Mosheim	Greene	Tennessee	37818	(423) 422-2126	
Dr.	Brooks	Morelock	M.D.	65 Payne Rd	Mosheim	Greene	Tennessee	37818	(423) 422-2126	(423) 422-2136
Dr.	George	Kehler	II	65 Payne Road	Mosheim	Greene	Tennessee	37818	(423) 422-2126	
Dr.	Brian	Maggard	M.D.	65 Payne Road	Mosheim	Greene	Tennessee	37818	(423) 422-2126	(423) 422-2165
Dr.	John	Shaw	M.D.	Recovery Associates of East Tennessee, 65 Payne Road	Mosheim	Greene	Tennessee	37818	(423) 422-2126	(423) 422-2136
Dr.	David	Merrifield	Jr., M.D.	The Lighthouse Counseling Services, PLLC, 218 East Washington Street	Rogersville	Hawkins	Tennessee	37857	(423) 293-3141	(423) 293-3142
Dr.	Charles	Fulton	M.D.	Charles A. Fulton MD, 3763 Highway 11 West	Blountville	Sullivan	Tennessee	37617	(423) 279-3860	(423) 279-3861
Dr.	Mack	Hicks	M.D.	Addiction Recovery Center of East Tennes, 3763 Highway 11 West	Blountville	Sullivan	Tennessee	37617	(423) 279-3861	(423) 230-8218
Dr.	Linden	Fernando		2726 West State Street	Bristol	Sullivan	Tennessee	37620	(423) 758-6744	(423) 758-6741
Dr.	Shawn	Nelson	M.D.	3183 West State Street, Suite 1201	Bristol	Sullivan	Tennessee	37620	(423) 764-2165	(423) 764-0717
Dr.	Matthew	Gangwer	M.D.	1895 Highway 126	Bristol	Sullivan	Tennessee	37620	(423) 232-0222	(423) 232-0223
Dr.	Elena	Aguas	M.D.	133 Canterbury Place	Bristol	Sullivan	Tennessee	37620	(423) 956-8472	(423) 989-3352
Dr.	Constantin	Diaz-Miranda	M.D.	1627 Higway 11 West	Bristol	Sullivan	Tennessee	37620	(423) 274-0100	(423) 274-0104
Dr.	Craig	Graul	D.O.	104 Manchester Place	Bristol	Sullivan	Tennessee	37620	(423) 341-3493	(423) 573-1988
Dr.	Stephen	Wayne	M.D.	3183 West State Street, Suite 1201	Bristol	Sullivan	Tennessee	37620	(423) 764-0987	(423) 764-2070
Dr.	Borzou	Azima	M.D.	1627 Highway 11 W	Bristol	Sullivan	Tennessee	37620	(423) 274-0100	(423) 274-0104
Dr.	John	Sherrill	M.D.	607 Holston Avenue, Suite B	Bristol	Sullivan	Tennessee	37620	(423) 968-1772	(423) 968-5736
Dr.	Joseph	Radawi	M.D.	Appalachian Recovery Care, PLLC, 2726 West State Street	Bristol	Sullivan	Tennessee	37620	(423) 758-6744	(423) 758-6741
Dr.	Gary	Neal	M.D.	260 Midway Medical Park, Suite 2G	Bristol	Sullivan	Tennessee	37620	(423) 968-4444	(423) 844-0359
Dr.	Stefan	Grenvik	M.D.	350 Blountville Highway, Suite 207	Bristol	Sullivan	Tennessee	37620	(423) 968-4540	(423) 968-5697
Dr.	Paul	Moran	III, M.D.	113 Landmark Lane, Suite A	Bristol	Sullivan	Tennessee	37620	(423) 573-7284	(423) 573-7268
Dr.	Michael	Lady		Pathway Medical Group Inc., 2124 Volunteer Parkway Suite B&C	Bristol	Sullivan	Tennessee	37620	(423) 573-7284	(423) 573-7268
Dr.	Steven	Kopitzke	M.D.	2124 Volunteer Parkway, Suite B	Bristol	Sullivan	Tennessee	37620	(423) 573-7284	(423) 573-7268
Dr.	John	Barrowclough	M.D.	Appalachian Recovery Care, PLLC, 2726 West State Street	Bristol	Sullivan	Tennessee	37620	(423) 758-6744	(423) 758-6741
Dr.	John	Tasker	M.D.	1303 East Center Street	Kingsport	Sullivan	Tennessee	37660	(423) 384-2820	(423) 245-6763
Dr.	Randall	Falconer	M.D.	Recovery Assist LLC, 1728 North Eastman Road	Kingsport	Sullivan	Tennessee	37660	(423) 765-0089	(423) 230-4850
Dr.	William	Platt	M.D.	2204 Pavilion Drive, Suite 107	Kingsport	Sullivan	Tennessee	37660	(423) 392-8100	(423) 392-8105

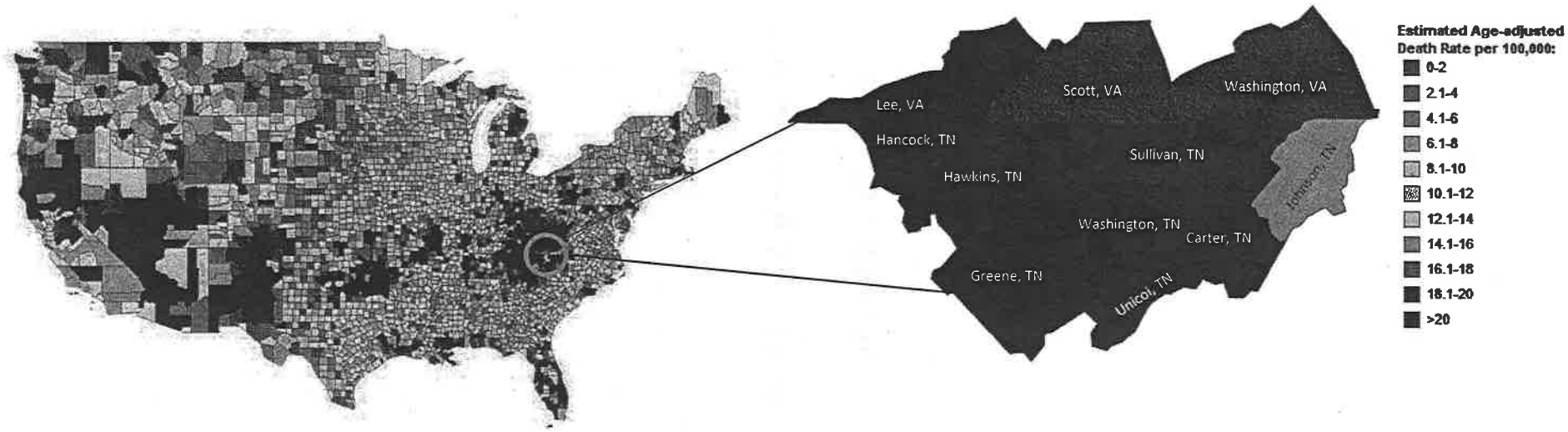
Dr.	Jonathan	Wireman	M.D.	1901 Brookside Drive, Suite 101	Kingsport	Sullivan	Tennessee	37660	(866) 755-4258	
Dr.	Pyung	Suh	M.D.	1729 Lynn Garden Drive	Kingsport	Sullivan	Tennessee	37660	(423) 288-0223	(423) 288-0220
Dr.	James	Burleson	M.D.	2545 Essex Drive	Kingsport	Sullivan	Tennessee	37660	(423) 288-6881	(423) 857-7872
Dr.	Daniel	Dickerson	M.D.	208 Lynn Garden Drive	Kingsport	Sullivan	Tennessee	37660	(423) 247-8811	(423) 245-5864
Dr.	Arthur	Boyd	M.D.	1901 Brookside Drive, Suite 101	Kingsport	Sullivan	Tennessee	37660	(866) 755-4258	(423) 343-9582
Dr.	Michael	Martin	M.D.	1936 Brookside Drive, Suite C	Kingsport	Sullivan	Tennessee	37660	(423) 384-4026	
Dr.	Charles	Herrin	M.D.	2300 Pavilion Drive	Kingsport	Sullivan	Tennessee	37660	(423) 857-5571	(423) 857-5237
Dr.	Peter	Bockhorst	M.D.	201 Cassel Drive	Kingsport	Sullivan	Tennessee	37660	(423) 245-9600	(423) 245-9631
Dr.	Sachdev	Somiah	M.D.	1401 Bridgewater Lane, Suite 1	Kingsport	Sullivan	Tennessee	37660	(423) 245-2406	(423) 245-2404
Dr.	Nicholas	Smith	M.D.	4600 Fort Henry Drive	Kingsport	Sullivan	Tennessee	37663	(423) 224-3950	(423) 224-3959
Dr.	Bendik	Clark	M.D.	1729 Lynn Garden Drive	Kingsport	Sullivan	Tennessee	37665	(423) 288-0223	(423) 288-0220
Dr.	Seth	Thompson	M.D.	300 Valley Street, North East	Abingdon	Washington	Virginia	24210	(276) 206-8197	(276) 206-8761
Dr.	Dan	Nicolau		Dan Nicolau, MD300 Valley Street N.E.	Abingdon	Washington	Virginia	24210	(276) 206-8197	(276) 206-8761
Dr.	Melanie	Skeen	D.O.	Premier 1 Healthcare, LLC793 West Main Street, Suite 7	Abingdon	Washington	Virginia	24210	(276) 525-4091	(276) 525-4092
Dr.	Keith	White	M.D.	300 Valley Street, NE	Abingdon	Washington	Virginia	24210	(276) 206-8197	(276) 206-8761
Dr.	George	Halstead	M.D.	2426 Lee Highway	Bristol	Washington	Virginia	24211	(276) 285-3911	(276) 285-3920
Dr.	Robert	Evans	M.D.	300 Valley Street NE	Abingdon	Washington	Virginia	24210	(276) 206-8197	(276) 206-8761
Dr.	Aishat	Shielu	M.D.	793 West MainSuite 7	Abingdon	Washington	Virginia	24210	(276) 525-4091	(276) 525-4092
Dr.	Gurcharan	Kanwal	M.D.	Watauga Recovery Centers, 198 Ross Carter Boulevard	Duffield	Scott	Virginia	24244	(276) 431-2900	(276) 431-2904
Dr.	Rodolfo	Cartagena	M.D.	198 Ross Carter Boulevard	Duffield	Scott	Virginia	24244	(276) 431-2900	(276) 431-2904
Dr.	Neal	Sanders	M.D.	198 Ross Carter Boulevard	Duffield	Scott	Virginia	24244	(276) 431-2900	(276) 431-2904
Dr.	Art	Van Zee	M.D.	St. Charles Clinic, P.O. Drawer S	Saint Charles	Lee	Virginia	24282	(276) 383-4428	(276) 383-4927

Count: 120

ATTACHMENT C, NEED (3)

National Map of Drug Poisoning Related Deaths

Estimated age-adjusted Death Rates for Drug Poisoning - 2014



Source: DCD/NCSH Vital Statistics System

ATTACHMENT C, NEED (4)

Drive Time Assessment

City	County	Proposed Site	Other Nearby MAT Locations - Tennessee & Virginia								
		★ 203 Gray Commons Circle, Johnson City, TN	TN - DRD Knoxville Medical Clinic (Bernard)	TN - DRD Knoxville Medical Clinic Central (Citico)	VA - Galax Treatment Center, Inc Cedar Bluff	VA - Addiction Recovery Systems, LLC Charlottesville	VA - Crossroads Treatment Center of Danville, PC	VA - Galax Treatment Center, Inc., Galax (Larkspur)	VA - Galax Treatment Center, Inc., Galax (Painter)	VA - Pulaski Medical	VA - Virginia Treatment Center, Inc., Roanoke
Johnson City TN	Washington, TN	15 min/11.2 mi	96 min/107 mi	95 min/107 mi	96 min/91.4 mi	262 min/295 mi	217 min/219 mi	133 min/142 mi	138 min/144 mi	119 min/131 mi	162 min/181 mi
Kingsport TN	Sullivan, TN	19 min/15.6 mi	92 min/99 mi	90 min/99 mi	87 min/66.3 mi	257 min/281 mi	211 min/205 mi	128 min/128 mi	132 min/130 mi	113 min/117 mi	157 min/167 mi
Bristol TN	Sullivan, TN	31 min/27.6 mi	103 min/113 mi	101 min/113 mi	65 min/55.8 mi	231 min/259 mi	185 min/183 mi	101 min/106 mi	106 min/108 mi	87 min/95.3 mi	131 min/145 mi
Mountain City TN	Johnson, TN	71 min/55.0 mi	148 min/155 mi	146 min/155 mi	90 min/70.1 mi	242 min/258 mi	188 min/186 mi	104 min/73.9 mi	100 min/72.3 mi	98 min/93.9 mi	141 min/144 mi
Elizabethton TN	Carter, TN	29 min/20.2 mi	108 min/115 mi	109 min/115 mi	93 min/82.1 mi	259 min/285 mi	213 min/210 mi	129 min/133 mi	134 min/132 mi	115 min/122 mi	159 min/171 mi
Greeneville TN	Greene, TN	44 min/28.8 mi	67 min/70.8 mi	66 min/70.6 mi	115 min/105 mi	282 min/312 mi	237 min/237 mi	153 min/160 mi	157 min/162 mi	138 min/149 mi	181 min/198 mi
Erwin TN	Unicoi, TN	28 min/25.6 mi	107 min/101 mi	107 min/101 mi	109 min/105 mi	275 min/309 mi	230 min/233 mi	147 min/156 mi	151 min/158 mi	132 min/145 mi	175 min/195 mi
Rogersville TN	Hawkins, TN	48 min/41.4 mi	75 min/73.6 mi	73 min/73.4 mi	114 min/93.1 mi	288 min/315 mi	242 min/240 mi	158 min/162 mi	162 min/164 mi	143 min/151 mi	188 min/201 mi
Sneedville, TN	Hancock, TN	83 min/64.1 mi	87 min/69.3 mi	85 min/69.1 mi	132 min/102 mi	346 min/335 mi	273 min/251 mi	190 min/174 mi	195 min/176 mi	175 min/163 mi	219 min/213 mi
Abingdon VA	Washington, VA	42 min/42.2 mi	112 min/128 mi	111 min/128 mi	48 min/41.7 mi	218 min/244 mi	172 min/169 mi	88 min/91.6 mi	92 min/93.3 mi	72 min/80.2 mi	117 min/130 mi
Duffield, VA	Scott, VA	46 min/39.0 mi	114 min/124 mi	113 min/124 mi	92 min/76.6 mi	277 min/301 mi	234 min/225 mi	149 min/146 mi	153 min/150 mi	134 min/137 mi	177 min/187 mi
Pennington Gap, VA	Lee, VA	65 min/54.4 mi	127 min/100 mi	127 min/101 mi	107 min/90.1 mi	299 min/317 mi	252 min/241 mi	169 min/164 mi	174 min/166 mi	154 min/153 mi	198 min/203 mi

City	County	Proposed Site	Other Nearby MAT Locations - North Carolina & Kentucky								
		★ 203 Gray Commons Circle, Johnson City, TN	NC - BHG XXXVI Asheville	NC - Western Carolina Treatment Center, Asheville	NC - Crossroads Treatment Center of Asheville, PC	NC - ATS of NC, Inc. Mountain Health Solutions - Asheville	NC - Crossroads Treatment Center of Weaverville, PC	NC - McLeod Addictive Disease Center - Boone	NC - Stepping Stones Wellness Center, LLC, Boone	KY - BHG XXVI, LLC Hazard	KY - BHG XXV, LLC Pikeville
Johnson City TN	Washington, TN	15 min/11.2 mi	65 min/65.5 mi	60 min/58.4 mi	66 min/66.5 mi	62 min/60.8 mi	45 min/45.6 mi	85 min/58.3 mi	79 min/55.4 mi	157 min/137 mi	129 min/118 mi
Kingsport TN	Sullivan, TN	19 min/15.6 mi	89 min/87.7 mi	86 min/80.6 mi	91 min/88.7 mi	87 min/83.0 mi	67 min/69.3 mi	111 min/80.9 mi	103 min/78.0 mi	136 min/113 mi	108 min/95.1 mi
Bristol TN	Sullivan, TN	31 min/27.6 mi	98 min/90.2 mi	93 min/83.1 mi	98 min/91.2 mi	94 min/85.5 mi	75 min/69.1 mi	93 min/69.7 mi	88 min/68.5 mi	158 min/129 mi	129 min/111 mi
Mountain City TN	Johnson, TN	71 min/55.0 mi	114 min/99.1 mi	109 min/92.0 mi	114 min/100 mi	111 min/94.4 mi	93 min/79.1 mi	40 min/26.8 mi	35 min/25.6 mi	183 min/144 mi	154 min/125 mi
Elizabethton TN	Carter, TN	29 min/20.2 mi	78 min/72.8 mi	73 min/65.8 mi	78 min/73.8 mi	75 min/68.2 mi	56 min/52.3 mi	71 min/47.3 mi	65 min/46.1 mi	171 min/145 mi	142 min/127 mi
Greeneville TN	Greene, TN	44 min/28.8 mi	81 min/60.7 mi	76 min/53.6 mi	81 min/61.7 mi	77 min/56.0 mi	69 min/47.5 mi	132 min/89.6 mi	126 min/86.7 mi	177 min/155 mi	148 min/136 mi
Erwin TN	Unicoi, TN	28 min/25.6 mi	52 min/51.3 mi	48 min/44.3 mi	53 min/52.3 mi	49 min/46.7 mi	32 min/31.2 mi	91 min/59.0 mi	85 min/56.1 mi	170 min/151 mi	141 min/132 mi
Rogersville TN	Hawkins, TN	48 min/41.4 mi	117 min/88.8 mi	112 min/81.8 mi	117 min/89.8 mi	114 min/84.2 mi	97 min/95.2 mi	139 min/108 mi	133 min/105 mi	169 min/117 mi	138 min/122 mi
Sneedville, TN	Hancock, TN	83 min/64.1 mi	130 min/123 mi	137 min/128 mi	132 min/127 mi	135 min/127 mi	134 min/118 mi	175 min/131 mi	168 min/128 mi	150 min/104 mi	125 min/99.8 mi
Abingdon VA	Washington, VA	42 min/42.2 mi	111 min/116 mi	107 min/109 mi	112 min/117 mi	108 min/112 mi	89 min/95.9 mi	80 min/55.0 mi	75 min/53.8 mi	141 min/115 mi	112 min/96.9 mi
Duffield, VA	Scott, VA	46 min/39.0 mi	112 min/112 mi	108 min/105 mi	113 min/113 mi	109 min/108 mi	93 min/92.8 mi	133 min/105 mi	127 min/103 mi	105 min/89.6 mi	77 min/71.3 mi
Pennington Gap, VA	Lee, VA	65 min/54.4 mi	133 min/128 mi	129 min/121 mi	134 min/129 mi	130 min/123 mi	113 min/108 mi	154 min/121 mi	147 min/118 mi	103 min/76.0 mi	89 min/78.0 mi

Source: Google Maps

Closest MAT location

2nd closest MAT location

ATTACHMENTS C, ECONOMIC FEASIBILITY (1)

Architect Documentation for Support of Estimated Construction Costs

THOMAS WEEMS ARCHITECT

May 16, 2016

Allison M. Rogers
Mountain States Health Alliance
Strategic Planning Department
303 Med Tech Parkway, Suite 330
Johnson City, TN 37604

Re: East Tennessee Healthcare Holdings, Inc.
203 Gray Commons Ctr., Suite 110
Gray, Tennessee

Dear Ms. Rogers,

As requested, we have prepared a preliminary budget for construction of the proposed clinic in Gray Commons, Gray Tennessee. The budget is based on the attached floor plan. The scope of work and budget breakdown is as follows:

Description:	Unit	Quantity	Unit Cost	Subtotal
Interior renovations including professional fees(architectural, construction contract fees, etc.), the construction of one wall and the addition of one door and frame in the medical and clinic directors' offices and finishes upgrades including painting and minor flooring and casework modifications	**SF**	**7851**	**$ 29.13**	**$228,711**
Total Construction Cost				**$228,711**

These figures do not include costs for furniture, licensing fees, IS equipment, or medical equipment. They only represent design and construction costs.

If you have any questions or require additional information, please feel free to contact our office.

Sincerely,

Thomas Weems

Thomas Weems, AIA, ACHA
Thomas Weems Architect

Attachments: Floor Plan

SUPPLEMENTAL #1
May 25, 2016
10:45 a.m.

THOMAS WEEMS ARCHITECT

May 24, 2016

Allison M. Rogers
Mountain States Health Alliance
Strategic Planning Department
303 Med Tech Parkway, Suite 330
Johnson City, TN 37604

Re: East Tennessee Healthcare Holdings, Inc.
203 Gray Commons Ctr., Suite 110
Gray, Tennessee

Dear Ms. Rogers,

As requested, please accept this letter as affirmation that, when complete, the physical environment for the proposed outpatient treatment center at Gray Commons Circle, as depicted in the design document reviewed by our office will conform, to the best of our knowledge, to applicable federal standards, manufacturer's specifications, and licensing agencies' requirements including the latest AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.

If you have any questions or require additional information, please feel free to contact our office.

Sincerely,

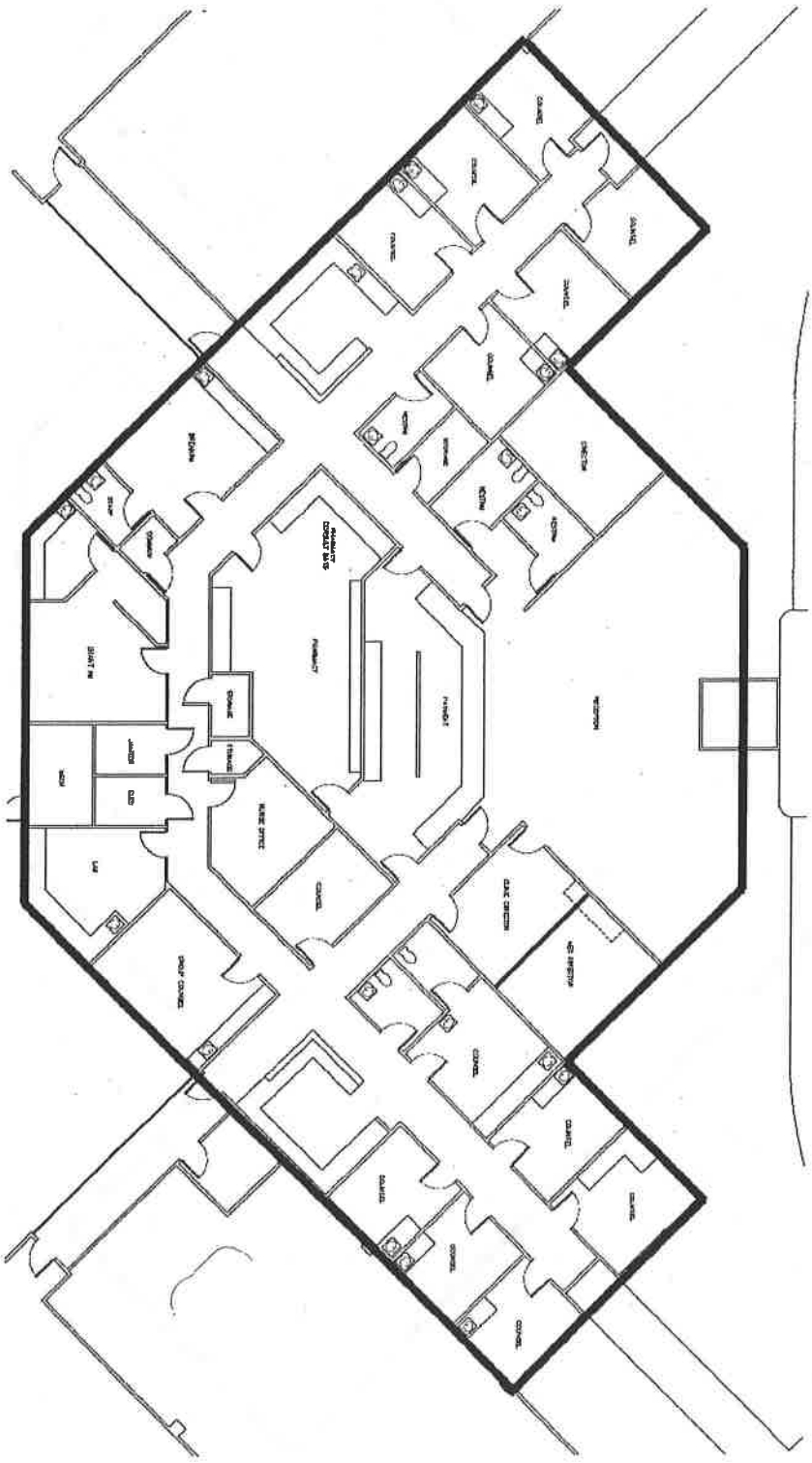
Thomas Weems, AIA, ACHA
Thomas Weems Architect

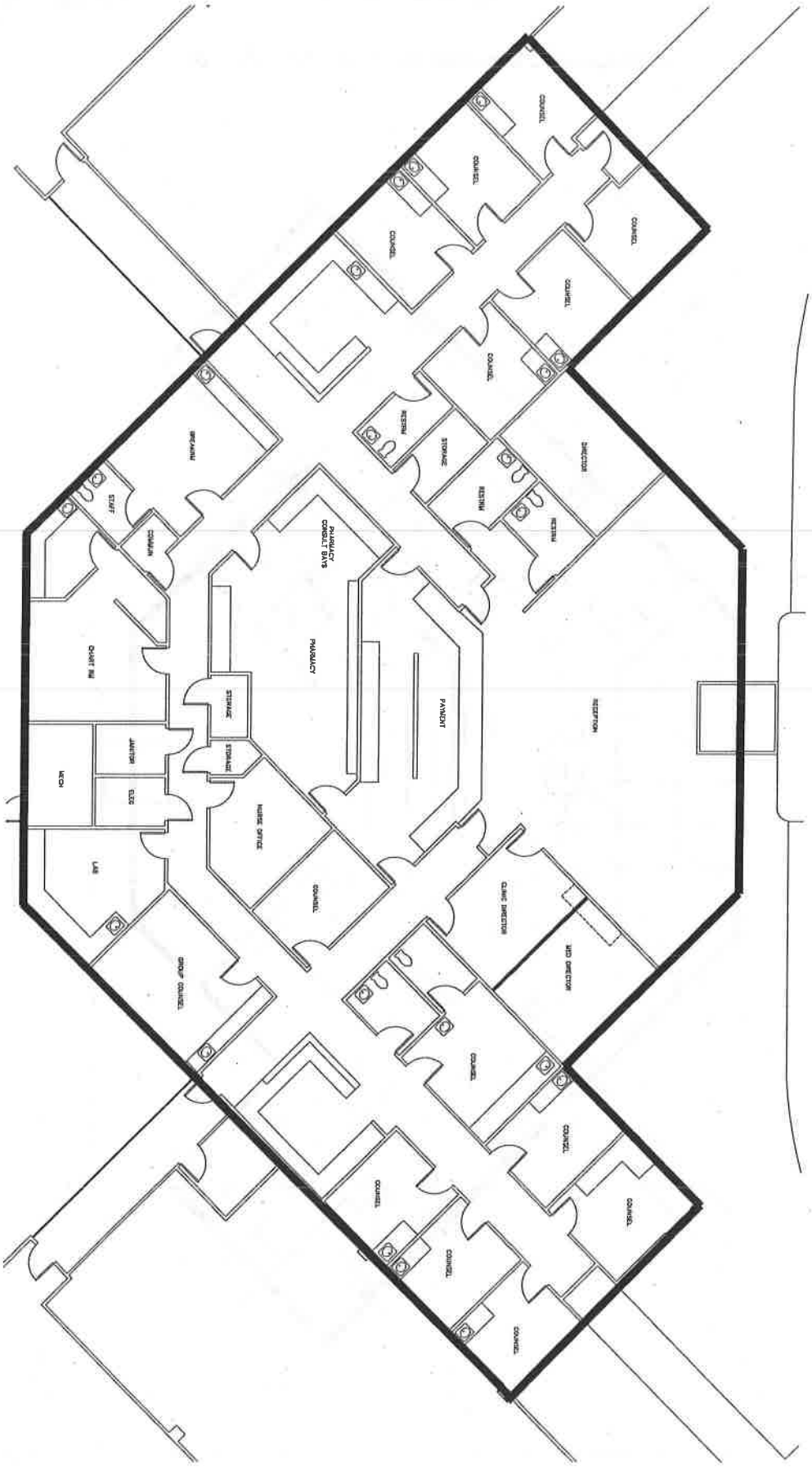
3203 hanover road · johnson city · tennessee 37604 · phone 423-952-2700 · fax 423-952-2702 · www.thomasweemsarchitect.com

SUPPLEMENTAL #1
May 25, 2016
10:45 a.m.

Exhibit A

Proposed Floor Plan for Suite 110 (7,851 SF)




COUNSEL
COUNSEL
COUNSEL
COUNSEL
COUNSEL
RESTR
STORAGE
RESTR
RESTR
DIRECTOR
BREAKRM
STAFF
TOILET
PHARMACY
CONSULT BAYS
PHARMACY
CHART RM
STORAGE
STORAGE
PAYMENT
RECEPTION
JANITOR
MEN
WOM
LAB
NURSE OFFICE
COUNSEL
GROUP COUNSEL
CLINIC DIRECTOR
MED DIRECTOR
COUNSEL
COUNSEL
COUNSEL
COUNSEL
COUNSEL

ATTACHMENTS C, ECONOMIC FEASIBILITY (2)

Letter of Available Funds

MOUNTAIN STATES HEALTH ALLIANCE

400 N. State of Franklin Road • Johnson City, TN 37604
423-431-6111

May 11, 2016

Health Services and Development Agency
502 Deaderick Street
Andrew Jackson Bldg., 9th Floor
Nashville, TN 37243

Dear Agency Members:

This letter is to certify that Mountain States Health Alliance has sufficient cash of $1,747,777 to fund the project, as described in the certificate of need application, for the establishment of a non-residential substitution-based treatment center for opiate addiction to be located at 203 Gray Commons Circle, Johnson City (Washington County), TN 37615.

Sincerely,

Lynn Krutak

Lynn Krutak
Senior Vice President / Chief Financial Officer

ATTACHMENTS C, ECONOMIC FEASIBILITY (10)

Most Recent Audited Statements – FY2014 and FY2015 for Mountain States Health Alliance and ESTU Research Foundation

[redacted]

MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Information)

Years Ended June 30, 2015 and 2014

PYA
Certified Public Accountants

MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Information)
(Dollars in Thousands)

Years Ended June 30, 2015 and 2014

PERSHING YOAKLEY & ASSOCIATES, P.C.
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919
p: (865) 673-0844 | f: (865) 673-0173
www.pyapc.com

PYA
Certified Public Accountants

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Mountain States Health Alliance and its subsidiaries (the Alliance), which comprise the consolidated balance sheets as of June 30, 2015 and 2014, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatements, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Alliance's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Alliance's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Mountain States Health Alliance and its subsidiaries as of June 30, 2015 and 2014, and the results of their operations, changes in net assets, and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplemental information is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Pershing Yoakley & Associates PC

Knoxville, Tennessee
October 28, 2015

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets
(Dollars in Thousands)

	June 30, 2015	June 30, 2014
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 79,714	$ 59,185
Current portion of investments	19,598	25,029
Patient accounts receivable, less estimated allowances for uncollectible accounts of $73,805 in 2015 and $47,853 in 2014	162,256	161,318
Other receivables, net	33,286	45,502
Inventories and prepaid expenses	33,969	30,838
TOTAL CURRENT ASSETS	328,823	321,872
INVESTMENTS, less amounts required to meet current obligations	694,542	648,475
PROPERTY, PLANT AND EQUIPMENT, net	847,089	881,429
OTHER ASSETS		
Goodwill	156,596	156,613
Net deferred financing, acquisition costs and other charges	24,755	25,841
Other assets	53,040	48,350
TOTAL OTHER ASSETS	234,391	230,804
	$ 2,104,845	$ 2,082,580

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets - Continued
(Dollars in Thousands)

	June 30, 2015	June 30, 2014
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	$ 18,159	$ 18,648
Current portion of long-term debt and capital lease obligations	40,286	30,618
Accounts payable and accrued expenses	100,301	87,126
Accrued salaries, compensated absences and amounts withheld	72,066	72,181
Estimated amounts due to third-party payers, net	4,781	10,463
TOTAL CURRENT LIABILITIES	235,593	219,036
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	1,031,661	1,075,069
Estimated fair value of derivatives	2,541	10,603
Estimated professional liability self-insurance	8,461	8,957
Other long-term liabilities	38,683	35,974
TOTAL LIABILITIES	1,316,939	1,349,639
COMMITMENTS AND CONTINGENCIES - Notes D, F, G, and M		
NET ASSETS		
Unrestricted net assets		
Mountain States Health Alliance	583,287	541,979
Noncontrolling interests in subsidiaries	191,118	178,547
TOTAL UNRESTRICTED NET ASSETS	774,405	720,526
Temporarily restricted net assets		
Mountain States Health Alliance	13,303	12,204
Noncontrolling interests in subsidiaries	71	84
TOTAL TEMPORARILY RESTRICTED NET ASSETS	13,374	12,288
Permanently restricted net assets	127	127
TOTAL NET ASSETS	787,906	732,941
	$ 2,104,845	$ 2,082,580

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations
(Dollars in Thousands)

	Year Ended June 30,	
	2015	*2014*
Revenue, gains and support:		
Patient service revenue, net of contractual allowances and discounts	$ 1,116,954	$ 1,046,767
Provision for bad debts	(127,519)	(122,642)
Net patient service revenue	989,435	924,125
Premium revenue	32,184	10,683
Net investment gain	17,016	50,703
Net derivative gain	13,890	3,219
Other revenue, gains and support	36,571	62,457
TOTAL REVENUE, GAINS AND SUPPORT	1,089,096	1,051,187
Expenses and losses:		
Salaries and wages	345,155	340,589
Physician salaries and wages	80,279	77,636
Contract labor	5,416	4,282
Employee benefits	77,306	69,173
Fees	120,691	115,606
Supplies	176,050	163,699
Utilities	16,775	17,052
Medical costs	18,383	6,633
Other	81,477	79,980
Loss on early extinguishment of debt	-	4,622
Depreciation	67,210	69,437
Amortization	1,557	1,742
Interest and taxes	43,697	44,392
TOTAL EXPENSES AND LOSSES	1,033,996	994,843
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	$ 55,100	$ 56,344

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Changes in Net Assets
(Dollars in Thousands)

Year Ended June 30, 2015

	Mountain States Health Alliance	*Noncontrolling Interests*	*Total*
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over Expenses and Losses	$ 41,008	$ 14,092	$ 55,100
Pension and other defined benefit plan adjustments	(178)	(152)	(330)
Net assets released from restrictions used for the purchase of property, plant and equipment	478	-	478
Repurchases of noncontrolling interests, net	-	(1,014)	(1,014)
Distributions to noncontrolling interests	-	(355)	(355)
INCREASE IN UNRESTRICTED NET ASSETS	41,308	12,571	53,879
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	3,663	69	3,732
Net assets released from restrictions	(2,564)	(82)	(2,646)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	1,099	(13)	1,086
INCREASE IN TOTAL NET ASSETS	42,407	12,558	54,965
NET ASSETS, BEGINNING OF YEAR	554,310	178,631	732,941
NET ASSETS, END OF YEAR	$ 596,717	$ 191,189	$ 787,906

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Changes in Net Assets - Continued
(Dollars in Thousands)

Year Ended June 30, 2014

	Mountain States Health Alliance	*Noncontrolling Interests*	*Total*
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over Expenses and Losses	$ 48,058	$ 8,286	$ 56,344
Pension and other defined benefit plan adjustments	194	194	388
Net assets released from restrictions used for the purchase of property, plant and equipment	3,313	-	3,313
Noncontrolling interest in acquired subsidiary	-	914	914
Distributions to noncontrolling interests	-	(461)	(461)
INCREASE IN UNRESTRICTED NET ASSETS	51,565	8,933	60,498
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	4,693	88	4,781
Net assets released from restrictions	(5,265)	(56)	(5,321)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	(572)	32	(540)
INCREASE IN TOTAL NET ASSETS	50,993	8,965	59,958
NET ASSETS, BEGINNING OF YEAR	503,317	169,666	672,983
NET ASSETS, END OF YEAR	$ 554,310	$ 178,631	$ 732,941

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	Year Ended June 30, 2015	2014
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase in net assets	$ 54,965	$ 59,958
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for depreciation and amortization	69,242	71,789
Provision for bad debts	127,519	122,642
Loss on early extinguishment of debt	-	4,622
Change in estimated fair value of derivatives	(7,718)	2,761
Equity in net income of joint ventures, net	(79)	(369)
Loss (gain) on disposal of assets	(2,192)	(3,489)
Amounts received on interest rate swap settlements	(6,172)	(5,980)
Capital Appreciation Bond accretion and other	2,780	2,629
Restricted contributions	(3,732)	(4,781)
Pension and other defined benefit plan adjustments	330	(388)
Increase (decrease) in cash due to change in:		
Patient accounts receivable	(128,457)	(115,380)
Other receivables, net	12,303	(11,880)
Inventories and prepaid expenses	(3,131)	959
Trading securities	(39,873)	(46,451)
Other assets	(3,128)	(2,492)
Accrued interest payable	(489)	(1,058)
Accounts payable and accrued expenses	16,745	(6,666)
Accrued salaries, compensated absences and amounts withheld	(115)	8,006
Estimated amounts due to third-party payers, net	(5,682)	(16,312)
Estimated professional liability self-insurance	(496)	199
Other long-term liabilities	2,379	16,425
Total adjustments	30,034	14,786
NET CASH PROVIDED BY OPERATING ACTIVITIES	84,999	74,744
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of property, plant and equipment and property held for expansion	(44,569)	(64,424)
Acquisitions, net of cash acquired	-	(4,256)
Purchases of held-to-maturity securities	(1,417)	(5,978)
Net distribution from joint ventures and unconsolidated affiliates	4,859	661
Proceeds from sale of property, plant and equipment and property held for resale	2,654	2,858
NET CASH USED IN INVESTING ACTIVITIES	(38,473)	(71,139)

See notes to consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows - Continued
(Dollars in Thousands)

	Year Ended June 30,	
	2015	*2014*
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments on long-term debt and capital lease obligations, including deposits to escrow	(36,210)	(38,768)
Payment of acquisition and financing costs	-	(3,826)
Proceeds from issuance of long-term debt and other financing arrangements	-	11,916
Net amounts received on interest rate swap settlements	6,172	5,980
Restricted contributions received	4,041	5,376
NET CASH USED IN FINANCING ACTIVITIES	(25,997)	(19,322)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	20,529	(15,717)
CASH AND CASH EQUIVALENTS, beginning of year	59,185	74,902
CASH AND CASH EQUIVALENTS, end of year	$ 79,714	$ 59,185
SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:		
Cash paid for interest	$ 38,982	$ 40,546
Cash paid for federal and state income taxes	$ 917	$ 854
Construction related payables in accounts payable and accrued expenses	$ 5,034	$ 8,604
Assets contributed into joint venture	$ 8,668	$ -
Supplemental cash flow information regarding acquisitions:		
Assets acquired, net of cash	$ -	$ 12,715
Liabilities assumed	-	(8,459)
Acquisitions, net of cash acquired	$ -	$ 4,256

During the year ended June 30, 2014, the Alliance refinanced previously issued debt of $318,385.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements
(Dollars in Thousands)

Years Ended June 30, 2015 and 2014

NOTE A--ORGANIZATION AND OPERATIONS

Mountain States Health Alliance (the Alliance) is a tax-exempt entity with operations primarily located in Washington, Sullivan, Unicoi, and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The primary operations of the Alliance consist of eleven acute and specialty care hospitals.

The Alliance's accompanying consolidated financial statements include all assets, liabilities, revenues, expenses, and changes in net assets attributable to the noncontrolling interests in the following subsidiaries:

- Smyth County Community Hospital and Subsidiary - the Alliance holds an 80% interest
- Norton Community Hospital and Subsidiaries - the Alliance holds a 50.1% interest
- Johnston Memorial Hospital, Inc. and Subsidiaries - the Alliance holds a 50.1% interest

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices, real estate and ambulatory surgery centers and provides other healthcare services to individuals in Tennessee and Virginia.

The Alliance is a 99.9% shareholder of Integrated Solutions Health Network, LLC, a for-profit entity that owns a for-profit insurance company and an accountable care organization and administers a provider-sponsored health care delivery network,

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc., a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation: The accompanying consolidated financial statements include the accounts of the Alliance and its consolidated subsidiaries after elimination of all significant intercompany accounts and transactions.

Use of Estimates: The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the consolidated financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from these estimates.

Cash and Cash Equivalents: Cash and cash equivalents include all highly liquid investments with a maturity of three months or less when purchased. Cash and cash equivalents designated as assets limited as to use or uninvested amounts included in investment portfolios are not included as cash and cash equivalents.

Investments: Investments include trading securities and held-to-maturity securities. Within the trading securities portfolio, all debt securities and marketable equity securities with readily determinable fair values are reported at fair value based on quoted market prices. Investments without readily determinable fair values are reported at estimated fair market value utilizing observable and unobservable inputs. Investments which the Alliance has the positive intent and ability to hold to maturity are classified as held-to-maturity and are stated at amortized cost. Realized gains and losses are computed using the specific identification method for cost determination. Interest and dividend income is reported net of related investment fees.

Management evaluates whether unrealized losses on held-to-maturity investments indicate other-than-temporary impairment. Such evaluation considers the amount of decline in fair value, as well as the time period of any such decline. Management does not believe any investment classified as held-to-maturity is other-than-temporarily impaired at June 30, 2015.

Investments in joint ventures are reported under the equity method of accounting, which approximates the Alliance's equity in the underlying net book value. Other assets include investments in joint ventures of $5,180 and $1,364 at June 30, 2015 and 2014, respectively. During 2015, the Alliance contributed assets into a joint venture which owns and operates a rehabilitation hospital.

Inventories: Inventories, consisting primarily of medical supplies, are stated at the lower of cost or market with cost determined by first-in, first-out method.

Property, Plant and Equipment: Property, plant and equipment is stated on the basis of cost, or if donated, at the fair value at the date of gift. Generally, depreciation is computed by the straight-line method over the estimated useful life of the asset. Equipment held under capital lease obligations is amortized under the straight-line method over the shorter of the lease term or estimated useful life. Amortization of buildings and equipment held under capital leases is shown as a part of depreciation expense and accumulated depreciation in the accompanying consolidated financial statements. Renewals and betterments are capitalized and depreciated over their useful life, whereas costs of maintenance and repairs are expensed as incurred.

Interest costs incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The amount capitalized is net of investment earnings on assets limited as to use derived from borrowings designated for capital assets.

The Alliance reviews capital assets for indications of potential impairment when there are changes in circumstances related to a specific asset. If this review indicates that the carrying value of these assets may not be recoverable, the Alliance estimates future cash flows from operations and the eventual disposition of such assets. If the sum of these undiscounted future cash flows is less than the carrying amount of the asset, a write-down to estimated fair value is recorded. The Alliance did not recognize any impairment losses during 2015 and 2014.

Other assets include property held for resale and expansion of $19,316 and $20,793, respectively, at June 30, 2015 and 2014. Property held for resale and expansion primarily represents land contributed to, or purchased by, the Alliance plus costs incurred to develop the infrastructure of such land. Management annually evaluates its investment and records non-temporary declines in value when it is determined the ultimate net realizable value is less than the recorded amount. No such declines were identified in 2015 and 2014.

Goodwill: Goodwill is evaluated for impairment at least annually. The Alliance comprises a single reporting unit for evaluation of goodwill. Management performed an evaluation of goodwill for impairment considering qualitative and quantitative factors and does not believe the goodwill to be impaired as of June 30, 2015 and 2014. Management's estimates utilized in the evaluation contain significant estimates and it is reasonably possible that such estimates could change in the near term.

Deferred Financing, Acquisition Costs and Other Charges: Other assets include deferred financing, acquisition costs and other charges of $24,755 and $25,841 at June 30, 2015 and 2014, respectively. Deferred financing costs are amortized over the life of the respective bond issue using the average bonds outstanding method.

Derivative Financial Instruments: The Alliance is a party to various interest rate swaps. These financial instruments are not designated as hedges and have been presented at estimated fair market value in the accompanying Consolidated Balance Sheets as either current or long-term liabilities, based upon the remaining term of the instrument.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Self-insurance liabilities include estimated reserves for reported and unreported professional liability claims and are recorded at the estimated net present value of such claims. Other long-term liabilities include contributions payable and obligations under deferred compensation arrangements, a defined benefit pension plan, a post-retirement employee benefit plan as well as other liabilities which management estimates are not payable within one year.

Net Patient Service Revenue/Receivables: Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts, including estimated retroactive adjustments under reimbursement agreements with third-party payers.

Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. The Alliance's revenue recognition policies related to self-pay and other types of payers emphasize revenue recognition only when collections are reasonably assured.

Patient accounts receivable are reported net of both an estimated allowance for uncollectible accounts and an estimated allowance for contractual adjustments. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, Medicaid, TennCare and other third-party payment programs. Current operations include a provision for bad debts in the Consolidated Statements of Operations estimated based upon the age of the patient accounts receivable, historical writeoffs and recoveries and any unusual circumstances (such as local, regional or national economic conditions) which affect the collectibility of receivables, including management's assumptions about conditions it expects to exist and courses of action it expects to take. The primary uncertainty lies with uninsured patient receivables and deductibles, co-payments or other amounts due from individual patients. Additions to the allowance for uncollectible accounts result from the provision for bad debts. Patient accounts written off as uncollectible are deducted from the allowance for uncollectible accounts.

For uninsured patients that do not qualify for charity care, the Alliance recognizes revenue on the basis of discounted rates under the Alliance's self-pay patient policy. Under the policy, a patient who has no insurance and is ineligible for any government assistance program has their bill reduced to the amount which generally would be billed to a commercially insured patient. The Alliance's policy does not require collateral or other security for patient accounts receivable. The Alliance routinely accepts assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans or policies.

Charity Care: The Alliance accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the Alliance and various guidelines outlined by the Federal Government. These policies define charity as those services for which no payment is anticipated and, as such, charges at established rates are not included in net patient service revenue. Charges forgone, based on established rates, totaled $85,988 and $109,550 during 2015 and 2014, respectively. The estimated direct and indirect cost of providing these services totaled $17,953 and $24,011 in 2015 and 2014, respectively. Such costs are determined using a ratio of cost to charges analysis with indirect cost allocated.

In addition to the charity care services, the Alliance provides a number of other services to benefit the poor for which little or no payment is received. Medicare, Medicaid, TennCare and State indigent programs do not cover the full cost of providing care to beneficiaries of those programs. The Alliance also provides services to the community at large for which it receives little or no payment.

Excess of Revenue, Gains and Support Over Expenses and Losses: The Consolidated Statements of Operations and the Consolidated Statements of Changes in Net Assets includes the caption Excess of Revenue, Gains and Support Over Expenses and Losses (the Performance Indicator). Changes in unrestricted net assets which are excluded from the Performance Indicator, consistent with industry practice, include contributions of long-lived assets or amounts restricted to the purchase of long-lived assets, certain pension and related adjustments, and transactions with noncontrolling interests.

Income Taxes: The Alliance is classified as an organization exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code. As such, no provision for income taxes has been made in the accompanying consolidated financial statements for the Alliance and its tax-exempt subsidiaries. The Alliance's taxable subsidiaries are discussed in Note L. The Alliance has no significant uncertain tax positions at June 30, 2015 and 2014. At June 30, 2015, tax returns for 2011 through 2014 are subject to examination by the Internal Revenue Service.

Temporarily and Permanently Restricted Net Assets: Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. When a donor or time restriction expires; that is, when a stipulated time restriction ends or purpose restriction is fulfilled, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the Consolidated Statements of Operations and Changes in Net Assets as net assets released from restrictions. The Alliance's policy is to net contribution and grant revenues against related expenses and present such amounts as a part of other revenue, gains and support in the Consolidated Statements of Operations. Permanently restricted net assets have been restricted by donors to be maintained by the Alliance in perpetuity.

Premium Revenue: Premium revenue include premiums from individuals and the Centers for Medicare & Medicaid Services (CMS). CMS premium revenue is based on predetermined prepaid rates under Medicare risk contracts. Premiums are recognized in the month in which the members are entitled to health care services. Premiums collected in advance are deferred and recorded as unearned premium revenue. Premium deficiency losses are recognized when it is probable that expected future claim expenses will exceed future premiums on existing contracts. Management evaluated the need for a premium deficiency reserve and recorded an estimated reserve of $2,000 at June 30, 2015 and 2014.

Medicare Shared Savings Program (MSSP): The Alliance participates in CMS's Medicare Shared Savings Program which is designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. Accountable care organizations participating in the program are assigned beneficiaries by CMS and are entitled to share in the savings if they are able to lower growth in Medicare Parts A and B fee-for-service costs while meeting performance standards on quality of care. Utilizing statistical data and the

methodology employed by CMS, management estimated and recognized $2,857 and $5,425 of shared savings in 2015 and 2014, respectively.

Electronic Health Record (EHR) Incentives: The American Recovery and Reinvestment Act of 2009 (ARRA) provides for incentive payments under the Medicare and Medicaid programs for certain hospitals and physician practices that demonstrate meaningful use of certified EHR technology. The incentive payments are calculated based upon estimated discharges, charity care and other input data and are recorded upon the Alliance's attainment of program and attestation criteria. The incentive payments are subject to regulatory audit. During the years ending June 30, 2015 and 2014, the Alliance recognized EHR incentive revenues of $1,883 and $18,269, respectively. EHR incentive revenues are included in other revenue, gains and support in the accompanying Consolidated Statements of Operations. The Alliance incurs both capital expenditures and operating expenses in connection with the implementation of its various EHR initiatives. The amount and timing of these expenditures does not directly correlate with the timing of the Alliance's receipt or recognition of the EHR incentive payments.

Medical Costs: The cost of health care services is recognized in the period in which services are provided. Medical costs include an estimate of the cost of services provided to members by third-party providers, which have been incurred but not reported.

Subsequent Events: The Alliance evaluated all events or transactions that occurred after June 30, 2015, through October 28, 2015, the date the consolidated financial statements were available to be issued. During this period management did not note any material recognizable subsequent events that required recognition or disclosure in the June 30, 2015 consolidated financial statements, other than as disclosed in Note P.

Reclassifications: Certain 2014 amounts have been reclassified to conform with the 2015 presentation in the accompanying consolidated financial statements.

New Accounting Pronouncements: In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers*. Under ASU 2014-09, recognition of revenue occurs when a customer obtains control of promised goods or services in an amount that reflects the consideration which the entity expects to receive in exchange for those goods or services. In addition, the accounting standard requires disclosure of the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The standard is effective for fiscal years beginning after December 15, 2017. Management is currently evaluating the impact of adopting the accounting standard.

(Dollars in Thousands)

NOTE C--INVESTMENTS

Assets limited as to use are summarized by designation or restriction as follows at June 30:

	2015	2014
Designated or restricted:		
Under safekeeping agreements	$ 8,221	$ 8,220
By Board to satisfy regulatory requirements	1,529	6,759
Under bond indenture agreements:		
For debt service and interest payments	53,812	55,123
For capital acquisitions	8,507	16,127
	72,069	86,229
Less: amount required to meet current obligations	(19,598)	(25,029)
	$ 52,471	$ 61,200

Assets limited as to use consist of the following at June 30:

	2015	2014
Cash and cash equivalents	$ 49,665	$ 54,437
U.S. Government and agency securities	19,757	28,518
Corporate and foreign bonds	860	2,354
Municipal obligations	1,787	920
	$ 72,069	$ 86,229

Held-to-maturity securities (other than assets limited as to use) are carried at amortized cost and consist of the following at June 30:

	2015	2014
Cash and cash equivalents	$ 2,781	$ 220
Corporate and foreign bonds	30,967	35,131
Municipal obligations	5,765	3,408
	$ 39,513	$ 38,759

Held-to-maturity securities had gross unrealized gains and losses of $98 and $425, respectively, at June 30, 2015 and $206 and $456, respectively, at June 30 2014. At June 30, 2015, the Alliance held securities within the held-to-maturity portfolio with a fair value and unrealized loss of $12,710

(Dollars in Thousands)

and $359, respectively, which had been at an unrealized loss position for over one year. At June 30, 2014, the Alliance held securities within the held-to-maturity portfolio with a fair value and unrealized loss of $13,513 and $456, respectively, which had been at an unrealized loss position for over one year. At June 30, 2015, the contractual maturities of held-to-maturity securities were $10,020 due in one year or less, $16,580 due from one to five years and $12,913 due after five years.

Trading securities consist of the following at June 30:

	2015	2014
Cash and cash equivalents	$ 20,789	$ 50,623
U.S. Government and agency securities	76,167	69,805
Corporate and foreign bonds	95,726	96,749
Municipal obligations	23,330	21,409
U.S. equity securities	5,419	1,868
Mutual funds	293,983	253,301
Alternative investments	87,144	54,761
	$ 602,558	$ 548,516

The net investment gain is comprised of the following for the years ending June 30:

	2015	2014
Interest and dividend income, net of fees	$ 13,894	$ 12,074
Net realized gains on the sale of securities	9,260	15,311
Change in net unrealized gains on securities	(6,138)	23,318
	$ 17,016	$ 50,703

The Alliance is a member of Premier Inc.'s (Premier) group purchasing organization and holds Class B Units which are convertible into cash or Class A common stock over a seven year vesting period. The Alliance records an investment relative to the estimated fair value of its Class B units, $14,724 and $14,713 at June 30, 2015 and 2014, respectively. In addition, as the vesting period is tangential to the Alliance's continued participation in the group purchasing contract, the Alliance recorded a liability equivalent to the estimated fair value of the Class B units, which is included within other long-term liabilities in the Consolidated Balance Sheets. The liability is being amortized as a vendor incentive over the vesting period. During 2015 and 2014, the Alliance recognized $4,045 and $2,933, respectively, related to the vendor incentive which is included within other revenue, gains and support in the Consolidated Statements of Operations.

(Dollars in Thousands)

NOTE D--DERIVATIVE TRANSACTIONS

The Alliance is subject to an enforceable master netting arrangement in the form of an ISDA agreement with Bank of America, Merrill Lynch (BofAML). The ISDA agreement requires that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. As of June 30, 2015 and 2014, the Alliance was not required to post additional collateral. Under the terms of this agreement, offsetting of derivative contracts is permitted in the event of default of either party to the agreement.

The following is a summary of the interest rate swap agreements at June 30, 2015 and 2014:

Notional Amount	*Termination*	*Counterparty*	*Current Payments:* *Receive*	*Pay*	*Estimated Fair Value* *2015*	*2014*
$170,000	4/2026	BofAML	1.14%	0.00%	$ 5,205	$ 3,089
$95,000	4/2026	BofAML	1.14%	0.00%	2,929	1,748
$173,030	4/2034	BofAML	1.16%	0.00%	884	(1,884)
$82,055	7/2033	BofAML	67% USD-LIBOR-BBA	0.312% + USD-SIFMA	(8,253)	(9,365)
$50,000	7/2038	BofAML	67% (USD-LIBOR-BBA + 0.15%)	USD-SIFMA	(3,351)	(4,210)
$19,400	7/2018	BofAML	4.50%	1.05% + USD-SIFMA	48	63
$4,293	7/2015	First Tennessee Bank	0.00%	USD-LIBOR-BBA	(3)	(44)
					$ (2,541)	$ (10,603)

The Alliance recognized net settlement income on the interest rate swap agreements of $6,172 and $5,980 in 2015 and 2014, respectively.

(Dollars in Thousands)

NOTE E--PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment consist of the following at June 30:

	2015	2014
Land	$ 60,337	$ 60,722
Buildings and leasehold improvements	766,089	760,853
Property and improvements held for leasing	83,582	80,824
Equipment and information technology infrastructure	733,315	700,748
Buildings and equipment held under capital lease	249	340
	1,643,572	1,603,487
Less: Allowances for depreciation and amortization	(815,105)	(757,641)
	828,467	845,846
Construction in progress	18,622	35,583
	$ 847,089	$ 881,429

Accumulated depreciation and amortization on property and improvements held for leasing purposes is $29,520 and $27,500 at June 30, 2015 and 2014, respectively. Net interest capitalized was $925 and $1,533 for the years ended June 30, 2015 and 2014, respectively.

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS

Long-term debt and capital lease obligations consist of the following at June 30:

Description	*Rate as of June 30, 2015*	*Outstanding Balance 2015*	*2014*
2013 Hospital Revenue and Refunding Revenue Bonds:			
$61,180 variable rate tax-exempt term bond, due August 2031	1.15%	$ 327,785	$ 328,665
$47,970 variable rate tax-exempt term bond, due August 2032	0.93%		
$13,350 variable rate tax-exempt term bond, due August 2038	1.15%		
$89,370 variable rate tax-exempt term bonds, due August 2042	1.12% - 1.23%		
$16,235 variable rate tax-exempt term bond, due August 2043	0.07%		
$99,680 variable rate taxable term bond due August 2043	0.12%		
2012 Hospital Revenue Bonds: (net of unamortized premium of $1,696 and $1,756 at June 30, 2015 and 2014, respectively)			
$55,000 fixed rate tax-exempt term bond, due August 2042	5.00%	56,696	56,756
2011 Hospital Revenue and Refunding and Improvement Bonds:			
$74,795 variable rate tax-exempt term bonds, due July 2033	0.08%	94,320	104,710
$19,525 variable rate tax-exempt term bond, due July 2033	1.11%		

(Dollars in Thousands)

Description	*Rate as of June 30, 2015*	*Outstanding Balance 2015*	*2014*
2010 Hospital Revenue Refunding Bonds: (net of unamortized premium of $1,441 and $1,523 at June 30, 2015 and 2014, respectively)			
$33,960 fixed rate tax-exempt serial bonds, through 2020	4.00% to 5.00%	173,271	180,993
$4,355 fixed rate tax-exempt term bond, due July 2023	5.00%		
$14,985 fixed rate tax-exempt term bond, due July 2025	5.38%		
$4,250 fixed rate tax-exempt term bond, due July 2028	5.50%		
$19,230 fixed rate tax-exempt term bond, due July 2030	5.63%		
$95,050 fixed rate tax-exempt term bonds, due July 2038	6.00% - 6.50%		
2009 Hospital Revenue Bonds: (net of unamortized discount of $2,176 and $2,267 at June 30, 2015 and 2014, respectively)			
$14,425 fixed rate tax-exempt term bonds, due July 2019	7.25%	117,264	119,813
$21,730 fixed rate tax-exempt term bonds, due July 2029	7.50%		
$83,285 fixed rate tax-exempt term bonds, due July 2038	7.75% - 8.00%		
2007B Taxable Hospital Revenue Bonds:			
$15,920 variable rate taxable term bond due July 2019	0.12%	15,920	19,515
2006 Hospital First Mortgage Revenue Bonds: (net of unamortized premium of $123 and $129 at June 30, 2015 and 2014, respectively)			
$3,965 fixed rate tax-exempt serial bonds, through 2019	5.00%	167,143	167,864
$7,375 fixed rate tax-exempt term bond, due July 2026	5.25%		
$20,505 fixed rate tax-exempt term bond, due July 2031	5.50%		
$135,175 fixed rate tax-exempt term bond, due July 2036	5.50%		
2001 Hospital First Mortgage Revenue Bond:			
$19,400 fixed rate tax-exempt term bond, due July 2026	4.50%	19,400	20,400
2000 Hospital First Mortgage Revenue and Refunding Bonds:			
$42,000 fixed rate tax-exempt term bond, due July 2026	8.50%	81,538	81,006
$39,538 fixed rate tax-exempt Capital Appreciation Bond, interest and principal due July 2026 through 2030	6.63%		
Capitalized lease obligations secured by equipment			
Various monthly principal and interest payments through December 2016	Various	350	806
Notes payable secured by real estate			
Paid-off in 2015	Various	-	5,542
Promissory notes secured by assets of certain subsidiaries			
Various monthly principal and interest payments through 2019	Various	1,705	1,944
Term note			
Monthly principal payments of $60 plus variable rate interest beginning November 2012 through September 2015; remaining principal due October 2015	1.17%	16,160	16,883
Notes payable secured by equipment			
Various monthly principal and interest payments through 2016	Various	395	790
		1,071,947	1,105,687
Less current portion		(40,286)	(30,618)
		$ 1,031,661	$ 1,075,069

Capital Appreciation Bonds: The Series 2000 Bonds include $14,680 of insured Capital Appreciation Bonds. Such bonds bear a 0% coupon rate and have a yield of 6.625% annually. The Alliance recognizes interest expense and increases the amount of outstanding debt each year based upon this yield. Total principal and interest due at maturity (2026 through 2030) is $93,675.

Other: Outstanding tax-exempt bond obligations that were insured under municipal bond insurance policies were $81,538 and $81,006 at June 30, 2015 and 2014, respectively. Under terms of these policies, the insurer guarantees the Alliance's payment of principal and interest. At June 30, 2015 and 2014, the Alliance held $206,630 and $212,360, respectively, in variable rate demand bonds with letter of credit support and $231,395 and $240,530, respectively, in variable rate bonds held under direct purchase agreements.

Early Redemption: Essentially all of the Alliance's bonds are subject to redemption prior to maturity, including optional, mandatory sinking fund and extraordinary redemption, at various dates and prices as described in the respective Bond indentures and other documents.

Derecognized Bonds: In previous years, the Alliance advance refunded debt by placing required funds in irrevocable trusts in order to satisfy remaining scheduled principal and interest payments of the outstanding debt. Management, upon advice of legal counsel, believes the amounts deposited in such irrevocable trust accounts have contractually relieved the Alliance of any future obligations with respect to this debt. Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2015 due to previous advance refundings totaled $185,470.

The assets placed in the irrevocable trust accounts are also not recognized as assets of the Alliance. These assets consist primarily of various investments, as permitted by bond indentures and other documents, including United States Treasury obligations, an investment contract with MBIA Insurance Corporation (MBIA) in the original amount of $54,300, as well as the Series 2000C and 2000D Bonds which were purchased with the proceeds of the 2000A and 2000B Bonds specifically for the purpose of utilizing the Series 2000C and 2000D Bonds in the irrevocable trust. Therefore, certain of the assets held in the irrevocable trust accounts have future income streams contingent upon payments by the Alliance.

Financing Arrangements: The Alliance granted a deed of trust on Johnson City Medical Center and Sycamore Shoals Hospital to secure the payment of the outstanding bond indebtedness. The bonds are also secured by the Alliance's receivables, inventories and other assets as well as certain funds held under the documents pursuant to which the bonds were issued. The Johnston Memorial Hospital, Inc. and Subsidiaries (JMH) Series 2011 Hospital Refunding and Improvement Revenue Bonds are secured by pledged revenues of JMH, as defined in the Credit Agreement.

(Dollars in Thousands)

Certain members of the Alliance and JMH are each members of separate Obligated Groups. The bond indentures, master trust indentures, letter of credit agreements and loan agreements related to the various bond issues and notes payable contain covenants with which the respective Obligated Groups must comply. These requirements include maintenance of certain financial and liquidity ratios, deposits to trustee funds, permitted indebtedness, use of facilities and disposals of property. These covenants also require that failure to meet certain debt service coverage tests will require the deposit of all daily cash receipts of the Alliance into a trust fund. Management has represented the Alliance and JMH are in compliance with all such covenants at June 30, 2015.

The scheduled maturities and mandatory sinking fund payments of the long-term debt and capital lease obligations (excluding interest), exclusive of net unamortized original issue discount and premium, at June 30, 2015 are as follows:

Year Ending June 30,		
2016	$	40,286
2017		24,112
2018		24,793
2019		25,926
2020		27,048
Thereafter		928,699
		1,070,864
Net premium		1,083
	$	1,071,947

NOTE G--SELF-INSURANCE PROGRAMS

The Alliance is substantially self-insured for professional and general liability claims and related expenses. The Alliance maintains a $25,000 umbrella liability policy that attaches over the self-insurance limits of $10,000 per claim and a $15,000 annual aggregate retention. The Alliance's insurance program also provides professional liability coverage for certain affiliates and joint ventures.

The Alliance is also substantially self-insured for workers' compensation claims in the State of Tennessee and has established estimated liabilities for both reported and unreported claims. The Alliance maintains a stop-loss policy that attaches over the self-insurance limits of $1,000 per occurrence. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

(Dollars in Thousands)

At June 30, 2015, the Alliance is involved in litigation relating to medical malpractice and workers' compensation and other claims arising in the ordinary course of business. There are also known incidents occurring through June 30, 2015 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Management has estimated and accrued for the cost of these unreported claims based on historical data and actuarial projections. The estimated net present value of malpractice and workers' compensation claims, both reported and unreported, as of June 30, 2015 and 2014 was $12,616 and $13,220, respectively. The discount rate utilized was 5% at June 30, 2015 and 2014.

Additionally, the Alliance is self-insured for employee health claims and recognizes expense each year based upon actual claims paid and an estimate of claims incurred but not yet paid. Such amount is included in accounts payable and accrued expenses in the Consolidated Balance Sheets.

NOTE H--NET PATIENT SERVICE REVENUE

Patient service revenue, net of contractual allowances and discounts, is composed of the following for the years ended June 30:

	2015	*2014*
Third-party payers	$ 965,865	$ 933,491
Patients	151,089	113,276
Patient service revenue	$ 1,116,954	$ 1,046,767

Patient deductibles and copayments under third-party payment programs are included within the patient amounts above.

The Alliance also provides services to uninsured and underinsured patients that do not qualify for financial assistance. Based on historical experience, a significant portion of uninsured and underinsured patients are unable or unwilling to pay the portion of their bill for which they are financially responsible, and a significant provision for bad debts is recorded in the period the services are provided.

The Alliance's allowance for doubtful accounts totaled $73,805 and $47,853 at June 30, 2015 and 2014, respectively. The allowance for doubtful accounts increased from 23% of patient accounts receivable, net of contractual allowances in 2014 to 31% of patient accounts receivable, net of contractual allowances in 2015. The increase is mainly related to the growing popularity of high-deductible insurance plans resulting in higher deductibles and out-of-pocket costs for patients. Management's estimate of the allowance for doubtful accounts is an estimate subject to change in the

near term. The provision for bad debts associated with the Alliance's ancillary service lines are not significant.

NOTE I--THIRD-PARTY REIMBURSEMENT

The Alliance renders services to patients under contractual arrangements with Medicare, Medicaid, TennCare and various other commercial payers. The Medicare program pays for inpatient services on a prospective basis. Payments are based upon diagnosis related group assignments, which are determined by the patient's clinical diagnosis and medical procedures utilized. The Alliance also receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid and other low income patients. Most Medicare outpatient services are reimbursed on a prospectively determined payment methodology. The Medicare program also reimburses certain other services on the basis of reasonable cost, subject to various prescribed limitations and reductions.

Reimbursement under the State of Tennessee's Medicaid waiver program (TennCare) for inpatient and outpatient services is administered by various managed care organizations (MCOs) and is based on diagnosis related group assignments, a negotiated per diem or fee schedule basis. The Alliance also receives additional supplemental payments from the State of Tennessee and Medicaid. These payments recognized totaled $10,386 and $10,860 for the years ended June 30, 2015 and 2014, respectively.

The Virginia Medicaid program reimbursement for inpatient hospital services is based on a prospective payment system using both a per case and per diem methodology. Additional payments are made for the allowable costs of capital. Payments for outpatient services are transitioning from cost-based reimbursement principles to a prospective payment system. Full implementation of this transition is expected to take place over multiple years.

Amounts earned under the contractual agreements with the Medicare and Medicaid programs are subject to review and final determination by fiscal intermediaries and other appropriate governmental authorities or their agents. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. The impact of final settlements of cost reports or changes in estimates increased net patient service revenue by $3,076 and $6,201 in 2015 and 2014, respectively.

Activity with respect to audits and reviews of the governmental programs in the healthcare industry has increased and is expected to increase in the future. No additional specific reserves or allowances have been established with regard to these increased audits and reviews as management is not able to estimate such amounts, if any. Management believes that any adjustments from these increased audits and reviews will not have a material adverse impact on the consolidated financial statements.

However, due to uncertainties in the estimation, it is at least reasonably possible that management's estimate will change in 2016, although the amount of any change cannot be estimated.

Participation in the Medicare program subjects the Alliance to significant rules and regulations; failure to adhere to such could result in fines, penalties or expulsion from the program. Management believes that adequate provision has been made for any adjustments, fines or penalties which may result from final settlements or violations of other rules or regulations. Management has represented that the Alliance is in substantial compliance with these rules and regulations as of June 30, 2015.

The Alliance has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, preferred provider organizations and employer groups. The basis for payment under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

NOTE J--EMPLOYEE BENEFIT PLANS

The Alliance sponsors a defined contribution retirement plan (the Plan) which covers substantially all employees. The Alliance makes contributions to the Plan under a stratified system, whereby the Alliance's contribution percentage is based on each employee's years of service. Employees of certain other subsidiaries are covered by other plans, although such plans are not significant. The total expense related to defined contribution plans for the years ended June 30, 2015 and 2014 was $15,601 and $13,850, respectively.

NCH maintains a frozen defined benefit pension plan and a frozen post-retirement employee benefit plan. The accrued unfunded pension liability was $1,806 and $2,086, and the accrued unfunded post-retirement liability was $6,307 and $5,857 at June 30, 2015 and 2014, respectively.

The Alliance sponsors a secured executive benefit program (SEBP) for certain key executives. Contributions to the plan by the Alliance are based on an annual amount of funding necessary to produce a target benefit for the participants at their retirement dates, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed $1,727 and $511 to the plan during 2015 and 2014, respectively. Other assets at June 30, 2015 and 2014 include $13,030 and $11,302, respectively, related to the Alliance's portion of the benefits which are recoverable upon the death of the participant. In addition, the Alliance sponsors a Section 457(f) plan for certain key executives. Contributions to the Section 457(f) plan during 2015 and 2014 were not significant.

NOTE K--CONCENTRATION OF RISK

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia, a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local

(Dollars in Thousands)

residents and are insured under third-party payer agreements. Net patient service revenue from Washington County, Tennessee acute-care operations was approximately 52% of total net patient service revenue in 2015 and 2014.

The mix of receivables from patients and third-party payers based on charges at established rates is as follows as of June 30. The patient responsibility related to charges for which the third-party has not yet paid is included within the third-party payer categories.

	2015	*2014*
Medicare	41%	39%
Tenncare/Medicaid	15%	18%
Commercial	26%	28%
Other third-party payers	8%	8%
Patients	10%	7%
	100%	100%

Approximately 91% and 88% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2015 and 2014, respectively. Admitting physicians are primarily practitioners in the regional area.

The Hospital maintains bank accounts at various financial institutions covered by the Federal Deposit Insurance Corporation (FDIC). At times throughout the year, the Alliance may maintain bank account balances in excess of the FDIC insured limit. Management believes the credit risk associated with these deposits is not significant.

The Alliance routinely invests in investment vehicles as listed in Note C. The Alliance's investment portfolio is managed by outside investment management companies. Investments in corporate and foreign bonds, municipal obligations, money market funds, equities and other vehicles that are held by safekeeping agents are not insured or guaranteed by the U.S. government.

NOTE L--INCOME TAXES

BRMM and its subsidiaries file a consolidated federal tax return and separate state tax returns. As of June 30, 2015 and 2014, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of $30,700 and $27,085, respectively, related to operating loss carryforwards, which expire through 2033. At June 30, 2015 and 2014, BRMM had state net operating loss carryforwards of $75,619 and $74,191, respectively, which expire through 2029. The net operating loss carryforwards may be offset against future taxable income to the extent permitted by the Internal Revenue Code and Tennessee Code Annotated.

(Dollars in Thousands)

Net deferred tax assets related to these carryforwards and other deferred tax assets have been substantially offset through valuation allowances equal to these amounts. Income taxes paid relate primarily to state taxes for certain subsidiaries and federal alternative minimum tax.

NOTE M--OTHER COMMITMENTS AND CONTINGENCIES

Construction in Progress: Construction in progress at June 30, 2015 represents costs incurred related to various hospital and medical office building facility renovations and additions and information technology infrastructure. The Alliance has outstanding contracts and other commitments related to the completion of these projects, and the cost to complete these projects is estimated to be $30,508 at June 30, 2015. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

Employee Scholarships: The Alliance offers scholarships to certain individuals which require that the recipients return to the Alliance to work for a specified period of time after they complete their degrees. Amounts due are then forgiven over a specific period of time as provided in the individual contracts. If the recipient does not return and work the required period of time, the funds disbursed on their behalf become due immediately, and interest is charged until the funds are repaid. Other receivables at June 30, 2015 and 2014 include $7,095 and $8,685, respectively, related to students in school, graduates working at the Alliance and amounts due from others who are no longer in the scholarship program, net of an estimated allowance.

Operating Leases and Maintenance Contracts: Total lease expense for the years ended June 30, 2015 and 2014 was $7,414 and $7,901, respectively. Future minimum lease payments for each of the next five years and in the aggregate for the Alliance's noncancellable operating leases with remaining lease terms in excess of one year are as follows:

Year Ending June 30,		
2016	$	7,346
2017		4,614
2018		3,605
2019		3,279
2020		2,481
Thereafter		11,240
	$	32,565

NOTE N--FAIR VALUE MEASUREMENT

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2015 and 2014, and valuation methodologies considered appropriate. The estimates presented are not necessarily indicative of amounts the Alliance could realize in a current market exchange. The carrying value of substantially all financial instruments approximates fair value due to the nature or term of the instruments, except as described below.

Held-to-Maturity Securities: The estimated fair value of the Alliance's held-to-maturity securities at June 30, 2015 and 2014, is $39,186 and $38,508, respectively, and would be classified in level 2 of the fair value hierarchy (described below). The fair value is based on prices provided by the Alliance's investment managers and its custodian bank, which use a variety of pricing sources to determine market valuations.

Investment in Joint Ventures: It is not practical to estimate the fair market value of the investments in joint ventures.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Estimates of reported and unreported professional liability claims, pension and post-retirement liabilities are discounted to approximate their estimated fair value. It is not practical to estimate the fair market value of other long-term liabilities.

Long-Term Debt: The estimated fair value of the Alliance's long-term debt at June 30, 2015 and 2014, is $1,130,580 and $1,172,357, respectively, and would be classified in Level 2 in the fair value hierarchy. The fair value of long-term debt is estimated based upon quotes obtained from brokers for bonds and discounted future cash flows using current market rates for other debt. For long-term debt with variable interest rates, the carrying value approximates fair value.

FASB Accounting Standards Codification 820 establishes a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- Level 1 - Inputs based on quoted market prices for identical assets or liabilities in active markets at the measurement date.

- Level 2 - Observable inputs other than quoted prices included in Level 1, such as quoted prices for similar assets and liabilities in active markets; quoted prices for identical or similar assets and liabilities in markets that are not active; or other inputs that are observable or can

(Dollars in Thousands)

- be corroborated by observable market data. The Alliance's Level 2 investments are valued primarily using the market valuation approach.

- Level 3 - Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Alliance's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Alliance's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the asset or liability.

The following table sets forth, by level within the fair value hierarchy, the financial instruments measured at fair value as of June 30, 2015 and 2014:

	Total	*Level 1*	*Level 2*	*Level 3*
June 30, 2015				
Cash and cash equivalents	$ 70,439	$ 70,439	$ -	$ -
U.S. Government and agency securities	88,083	88,083	-	-
Corporate and foreign bonds	96,586	-	96,586	-
Municipal obligations	23,329	-	23,329	-
U.S. equity securities	5,419	5,419	-	-
Mutual funds	293,983	212,323	81,660	-
Alternative investments	87,144	-	72,420	14,724
Total assets	$ 664,983	$ 376,264	$ 273,995	$ 14,724
Derivative agreements	$ (2,541)	$ -	$ -	$ (2,541)
June 30, 2014				
Cash and cash equivalents	$ 98,956	$ 98,956	$ -	$ -
U.S. Government and agency securities	90,474	90,474	-	-
Corporate and foreign bonds	99,103	-	99,103	-
Municipal obligations	21,409	-	21,409	-
U.S. equity securities	1,868	1,868	-	-
Mutual funds	253,301	177,067	76,234	-
Alternative investments	69,474	-	54,761	14,713
Total assets	$ 634,585	$ 368,365	$ 251,507	$ 14,713
Derivative agreements	$ (10,603)	$ -	$ -	$ (10,603)

Fair values for the Alliance's fixed maturity securities are based on prices provided by the Alliance's investment managers and its custodian bank, which use a variety of pricing sources to determine market valuations. Fair values of equity securities have been determined by the Alliance from market quotations.

Alternative Investments: The Alliance generally uses net asset value per unit as provided by external investment managers without further adjustment as the practical expedient estimate of the fair value of its alternative investment in a real estate fund. Accordingly, such values may differ from values that would have been used had an active market for the investments existed. The real estate fund invests primarily in U.S. commercial real estate. The Alliance may request redemption of all or a portion of its interests as of the end of a calendar quarter by delivering written notice to the fund managers at least 60 days prior to the end of the quarter. Such redemptions are subject to the capital requirements of the fund manager.

The Alliance's investment in Premier Class B units does not have a readily determinable fair value and have been reported at estimated fair market value. The significant unobservable inputs primarily relate to management's estimate of the discount for lack of marketability of 12%. Accordingly, such value may differ from values that would have been used had an active market for the investment existed and as such it has been classified in Level 3 of the fair value hierarchy.

Derivative Agreements: The valuation of the Alliance's derivative agreements is determined using market valuation techniques, including discounted cash flow analysis on the expected cash flows of each agreement. This analysis reflects the contractual terms of the agreement, including the period to maturity, and uses certain observable market-based inputs. The fair values of interest rate agreements are determined by netting the discounted future fixed cash payments (or receipts) and the discounted expected variable cash receipts (or payments). The variable cash receipts (or payments) are based on the expectation of future interest rates and the underlying notional amount. The Alliance also incorporates credit valuation adjustments (CVAs) to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. The CVA on the Alliance's interest rate swap agreements at June 30, 2015 and 2014 resulted in a decrease in the fair value of the related liability of $713 and $4,584, respectively.

A certain portion of the inputs used to value its interest rate swap agreements, including the forward interest rate curves and market perceptions of the Alliance's credit risk used in the CVAs, are unobservable inputs available to a market participant. As a result, the Alliance has determined that the interest rate swap valuations are classified in Level 3 of the fair value hierarchy. Due to the nature of these financial instruments, such estimates of fair value are subject to significant change in the near term.

(Dollars in Thousands)

The following tables provide a summary of changes in the fair value of the Alliance's Level 3 financial assets and liabilities during the fiscal years ended June 30, 2015 and 2014:

	Alternative Investment	*Derivatives, Net*
July 1, 2013	$ -	$ (8,185)
Total unrealized/realized losses	-	(2,761)
Net investment income	-	343
Additions	14,713	-
June 30, 2014	14,713	(10,603)
Total unrealized/realized gains	6,978	7,718
Net investment income	-	344
Settlements	(6,967)	-
June 30, 2015	$ 14,724	$ (2,541)

NOTE O--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION

The Alliance does not present expense information by functional classification because its resources and activities are primarily related to providing healthcare services. Further, since the Alliance receives substantially all of its resources from providing healthcare services in a manner similar to business enterprises, other indicators contained in these consolidated financial statements are considered important in evaluating how well management has discharged their stewardship responsibilities.

NOTE P--SUBSEQUENT EVENTS

The Alliance and Wellmont Health System (Wellmont) have agreed to exclusively explore the creation of a new, integrated and locally governed health system. Wellmont operates six hospitals and numerous outpatient care sites, serving communities in Northeast Tennessee and Southwest Virginia. Wellmont and the Alliance have filed a letter of intent (LOI) with the Tennessee Department of Health, indicating the organizations will submit an application for a Certificate of Public Advantage (COPA). The two organizations have submitted a similar letter of intent with the Southwest Virginia Health Authority, signaling their intent to request approval by the commonwealth of the anticipated cooperative agreement between the two systems. A COPA in Tennessee and the cooperative agreement approval process in Virginia will allow Wellmont and the Alliance to merge, with the states actively supervising the proposed new health system to ensure it complies with the provisions of the COPA intended to contain costs and sustain high quality, affordable care. The two organizations are in the process of finalizing a definitive agreement. The date for expected completion of the merger has not been set but will not occur before state approval has been granted.

Supplemental Information

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets
(Smyth County Community Hospital and Subsidiary and Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)

June 30, 2015

	Smyth County Community Hospital and Subsidiary	*Norton Community Hospital and Subsidiaries*
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 2,940	$ 6,798
Patient accounts receivable, less estimated allowances for uncollectible accounts	6,295	11,137
Other receivables, net	156	310
Inventories and prepaid expenses	1,079	2,061
Estimated amounts due from third-party payers, net	793	292
TOTAL CURRENT ASSETS	11,263	20,598
INVESTMENTS, less amounts required to meet current obligations	24,807	30,451
PROPERTY, PLANT AND EQUIPMENT, net	67,550	50,275
OTHER ASSETS		
Net deferred financing, acquisition costs and other charges	139	210
Other assets	741	-
TOTAL OTHER ASSETS	880	210
	$ 104,500	$ 101,534

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets - Continued
(Smyth County Community Hospital and Subsidiary and Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)

June 30, 2015

	Smyth County Community Hospital and Subsidiary	*Norton Community Hospital and Subsidiaries*
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	$ 12	$ 15
Current portion of long-term debt and capital lease obligations	134	110
Accounts payable and accrued expenses	2,323	6,245
Accrued salaries, compensated absences and amounts withheld	2,116	4,388
Payables to affiliates, net	342	89
TOTAL CURRENT LIABILITIES	4,927	10,847
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	15,830	20,985
Estimated professional liability self-insurance	442	632
Other long-term liabilities	1,178	8,200
TOTAL LIABILITIES	22,377	40,664
NET ASSETS		
Unrestricted net assets	82,114	60,734
Temporarily restricted net assets	9	136
TOTAL NET ASSETS	82,123	60,870
	$ 104,500	$ 101,534

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations and Changes in Net Assets
(Smyth County Community Hospital and Subsidiary and Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)

Year Ended June 30, 2015

	Smyth County Community Hospital and Subsidiary	*Norton Community Hospital and Subsidiaries*
UNRESTRICTED NET ASSETS:		
Revenue, gains and support:		
Patient service revenue, net of contractual allowances and discounts	$ 48,370	$ 78,667
Provision for bad debts	(5,332)	(8,546)
Net patient service revenue	43,038	70,121
Net investment gain	651	746
Other revenue, gains and support	1,745	2,576
TOTAL REVENUE, GAINS AND SUPPORT	45,434	73,443
Expenses and losses:		
Salaries and wages	17,289	23,681
Physician salaries and wages	257	6,043
Contract labor	170	567
Employee benefits	4,365	8,965
Fees	9,050	8,326
Supplies	5,349	8,793
Utilities	978	1,286
Other	4,348	7,753
Depreciation	4,289	4,489
Amortization	8	30
Interest and taxes	156	257
TOTAL EXPENSES AND LOSSES	46,259	70,190
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	(825)	3,253
Pension and postretirement liability adjustments	-	(305)
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	(825)	2,948

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations and Changes in Net Assets - Continued
(Smyth County Community Hospital and Subsidiary and Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)

Year Ended June 30, 2015

	Smyth County Community Hospital and Subsidiary	*Norton Community Hospital and Subsidiaries*
TEMPORARILY RESTRICTED NET ASSETS:		
Restricted grants and contributions	8	134
Net assets released from restrictions	(8)	(160)
DECREASE IN TEMPORARILY RESTRICTED NET ASSETS	-	(26)
INCREASE (DECREASE) IN TOTAL NET ASSETS	(825)	2,922
NET ASSETS, BEGINNING OF YEAR	82,948	57,948
NET ASSETS, END OF YEAR	$ 82,123	$ 60,870

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet
(Obligated Group and Other Entities)
(Dollars in Thousands)

June 30, 2015

	Obligated Group	*Other Entities*	*Eliminations*	*Total*
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	$ 47,025	$ 32,689	$ -	$ 79,714
Current portion of investments	19,598	-	-	19,598
Patient accounts receivable, less estimated allowance for uncollectible accounts	134,777	27,479	-	162,256
Other receivables, net	17,873	15,413	-	33,286
Inventories and prepaid expenses	25,427	8,542	-	33,969
TOTAL CURRENT ASSETS	244,700	84,123	-	328,823
INVESTMENTS, less amounts required to meet current obligations	458,373	236,169	-	694,542
EQUITY IN AFFILIATES	351,724	-	(351,724)	-
PROPERTY, PLANT AND EQUIPMENT, net	614,870	232,219	-	847,089
OTHER ASSETS				
Goodwill	152,600	3,996	-	156,596
Net deferred financing, acquisition costs and other charges	23,504	1,251	-	24,755
Other assets	44,738	8,302	-	53,040
TOTAL OTHER ASSETS	220,842	13,549	-	234,391
	$ 1,890,509	$ 566,060	$ (351,724)	$ 2,104,845

See note to supplemental information.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet – Continued
(Obligated Group and Other Entities)
(Dollars in Thousands)

June 30, 2015

	Obligated Group	*Other Entities*	*Eliminations*	*Total*
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accrued interest payable	$ 18,125	$ 34	$ -	$ 18,159
Current portion of long-term debt and capital lease obligations	22,040	18,246	-	40,286
Accounts payable and accrued expenses	80,408	19,893	-	100,301
Accrued salaries, compensated absences and amounts withheld	54,519	17,547	-	72,066
Payables to (receivables from) affiliates, net	15,314	(15,314)	-	-
Estimated amounts due to third-party payers, net	3,909	872	-	4,781
TOTAL CURRENT LIABILITIES	194,315	41,278	-	235,593
OTHER LIABILITIES				
Long-term debt and capital lease obligations, less current portion	1,012,167	19,494	-	1,031,661
Estimated fair value of derivatives, net	2,541	-	-	2,541
Estimated professional liability self-insurance	7,362	1,099	-	8,461
Other long-term liabilities	35,176	3,507	-	38,683
TOTAL LIABILITIES	1,251,561	65,378	-	1,316,939
NET ASSETS				
Unrestricted net assets				
Mountain States Health Alliance	583,287	344,360	(344,360)	583,287
Noncontrolling interests in subsidiaries	42,160	143,222	5,736	191,118
TOTAL UNRESTRICTED NET ASSETS	625,447	487,582	(338,624)	774,405
Temporarily restricted net assets				
Mountain States Health Alliance	13,303	12,966	(12,966)	13,303
Noncontrolling interests in subsidiaries	71	7	(7)	71
TOTAL TEMPORARILY RESTRICTED NET ASSETS	13,374	12,973	(12,973)	13,374
Permanently restricted net assets	127	127	(127)	127
TOTAL NET ASSETS	638,948	500,682	(351,724)	787,906
	$ 1,890,509	$ 566,060	$ (351,724)	$ 2,104,845

See note to supplemental information.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Operations
(Obligated Group and Other Entities)
(Dollars in Thousands)

Year Ended June 30, 2015

	Obligated Group	*Other Entities*	*Eliminations*	*Total*
Revenue, gains and support:				
Patient service revenue, net of contractual allowances and discounts	$ 925,979	$ 203,883	$ (12,908)	$ 1,116,954
Provision for bad debts	(104,724)	(22,795)	-	(127,519)
Net patient service revenue	821,255	181,088	(12,908)	989,435
Premium revenue	-	32,184	-	32,184
Net investment gain	12,486	4,530	-	17,016
Net derivative gain	13,195	695	-	13,890
Other revenue, gains and support	27,244	97,465	(88,138)	36,571
Equity in net gain of affiliates	716	10,275	(10,991)	-
TOTAL REVENUE, GAINS AND SUPPORT	874,896	326,237	(112,037)	1,089,096
Expenses:				
Salaries and wages	284,643	67,093	(6,581)	345,155
Physician salaries and wages	64,838	71,222	(55,781)	80,279
Contract labor	3,101	2,913	(598)	5,416
Employee benefits	66,881	17,443	(7,018)	77,306
Fees	97,754	35,093	(12,156)	120,691
Supplies	146,516	29,660	(126)	176,050
Utilities	12,981	3,798	(4)	16,775
Medical Costs	-	30,566	(12,183)	18,383
Other	61,323	26,524	(6,370)	81,477
Depreciation	51,307	15,903	-	67,210
Amortization	1,488	69	-	1,557
Interest and taxes	41,599	2,098	-	43,697
TOTAL EXPENSES	832,431	302,382	(100,817)	1,033,996
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	$ 42,465	$ 23,855	$ (11,220)	$ 55,100

See note to supplemental information.

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Changes in Net Assets
(Obligated Group and Other Entities)
(Dollars in Thousands)

Year Ended June 30, 2015

	Obligated Group		Total	Other Entities		Total		
	Mountain States Health Alliance	Noncontrolling Interests	Obligated Group	Mountain States Health Alliance	Noncontrolling Interests	Other Entities	Eliminations	Total
UNRESTRICTED NET ASSETS:								
Excess of Revenue, Gains and Support over Expenses and Losses	$ 41,008	$ 1,457	$ 42,465	$ 13,832	$ 10,023	$ 23,855	$ (11,220)	$ 55,100
Pension and other defined benefit plan adjustments	(178)	(152)	(330)	(207)	(206)	(413)	413	(330)
Net assets released from restrictions used for the purchase of property, plant and equipment	478	-	478	478	-	478	(478)	478
Repurchases of noncontrolling interests, net	-	(1,000)	(1,000)	-	(14)	(14)	-	(1,014)
Distributions to noncontrolling interests	-	-	-	(458)	(355)	(813)	458	(355)
Net asset transfers	-	-	-	912	2,372	3,284	(3,284)	-
INCREASE IN UNRESTRICTED NET ASSETS	41,308	305	41,613	14,557	11,820	26,377	(14,111)	53,879
TEMPORARILY RESTRICTED NET ASSETS:								
Restricted grants and contributions	3,663	69	3,732	3,172	7	3,179	(3,179)	3,732
Net assets released from restrictions	(2,564)	(82)	(2,646)	(2,093)	(5)	(2,098)	2,098	(2,646)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	1,099	(13)	1,086	1,079	2	1,081	(1,081)	1,086
INCREASE IN TOTAL NET ASSETS	42,407	292	42,699	15,636	11,822	27,458	(15,192)	54,965
NET ASSETS, BEGINNING OF YEAR	554,310	41,939	596,249	341,817	131,407	473,224	(336,532)	732,941
NET ASSETS, END OF YEAR	$ 596,717	$ 42,231	$ 638,948	$ 357,453	$ 143,229	$ 500,682	$ (351,724)	$ 787,906

See note to supplemental information.

MOUNTAIN STATES HEALTH ALLIANCE

Note to Supplemental Information

Year Ended June 30, 2015

NOTE A--OBLIGATED GROUP MEMBERS

As described in Note F to the consolidated financial statements, the Alliance has granted a deed of trust on JCMC and SSH to secure the payment of the outstanding bonds. The bonds are also secured by the Alliance's receivables, inventories and other assets as well as certain funds held under the documents pursuant to which the bonds were issued. The members pledged pursuant to the Amended and Restated Master Trust Indenture between Mountain States Health Alliance and the Bank of New York Mellon Trust Company, NA as Master Trustee include Johnson City Medical Center Hospital, Indian Path Medical Center, Franklin Woods Community Hospital, Sycamore Shoals Hospital, Johnson County Community Hospital, Russell County Medical Center, Unicoi County Memorial Hospital, Norton Community Hospital (hospital only), Smyth County Community Hospital (hospital only) and Blue Ridge Medical Management Corporation (parent company only), collectively defined as the Obligated Group (Obligated Group).

The supplemental consolidating information includes the accounts of the members of the Obligated Group after elimination of all significant intergroup accounts and transactions. Certain other subsidiaries of the Alliance are not pledged to secure the payment of the outstanding bonds as they are not part of the Obligated Group. These affiliates have been accounted for within the Obligated Group based upon the Alliance's original and subsequent investments, as adjusted for the Alliance's pro rata share of income or losses and any distributions, and are included as a part of equity in affiliates in the supplemental consolidating balance sheet.

EAST TENNESSEE STATE UNIVERSITY
RESEARCH FOUNDATION

Financial Statements

June 30, 2015 and 2014

EAST TENNESSEE STATE UNIVERSITY RESEARCH FOUNDATION
Financial Statements
June 30, 2015 and 2014

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• Certified Public Accountants
• Business Advisors

p: 423.246-4062
f: 423.247-2028
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433 E. Center Street, P.O. Box 1818
Kingsport, TN 37662

RODEFER MOSS & CO, PLLC

Independent Auditors' Report

Board of Directors
East Tennessee State University Research Foundation
Johnson City, Tennessee

Report on the Financial Statements

We have audited the accompanying financial statements of the business-type activities of East Tennessee State University Research Foundation ("the Foundation") as of and for the years ended June 30, 2015 and 2014, and the related notes to the financial statements which collectively comprise the Foundation's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the Foundation, as of June 30, 2015 and 2014, and the respective changes in financial position and cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the principal official's discussion and analysis as listed in the table of contents be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated December 8, 2015, on our consideration of the Foundation's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Foundation's internal control over financial reporting and compliance.

Rodefer Moss & Co, PLLC

Kingsport, Tennessee
December 8, 2015

EAST TENNESSEE STATE UNIVERSITY RESEARCH FOUNDATION
Principal Officials
June 30, 2015

Board of Directors

Dr. Brian Noland	Chairman
Dr. Jon Smith	Secretary
Dr. David Collins	Treasurer
Mr. Jeremy Ross	Executive Director
Dr. Bert Bach	Director
Dr. Wilsie Bishop	Director
Dr. David Williams	Director
Mr. Phil Carriger	Director

Management

Dr. William Duncan	President

EAST TENNESSEE STATE UNIVERSITY RESEARCH FOUNDATION
Management's Discussion and Analysis
June 30, 2015 and 2014

This section of the East Tennessee State University Research Foundation's (the "Foundation") annual financial report presents a discussion and analysis of the financial performance of the Foundation during the fiscal year ended June 30, 2015 with comparative information presented for fiscal years ended June 30, 2014 and June 30, 2013. This discussion has been prepared by management along with the financial statements and related footnote disclosures and should be read in conjunction with them. The financial statements, footnotes, and this discussion are the responsibility of management.

Overview of the Financial Statements

The financial statements have been prepared in accordance with generally accepted accounting principles as prescribed by the Governmental Accounting Standards Board (GASB), which establishes standards for external financial reporting for entities. The full scope of the Foundation's activities is considered to be a single business-type activity, and accordingly, is reported within a single column in the basic financial statements.

The Statements of Net Position

The Statements of Net Position is a point in time financial statement. The Statements of Net Position present the financial position of the Foundation at the end of the fiscal year. To aid the reader in determining the Foundation's ability to meet immediate and future obligations, the statements include all assets, liabilities, deferred outflows/inflows, and net position of the Foundation and segregate the assets and liabilities into current and noncurrent components. Current assets are those that are available to satisfy current liabilities, inclusive of assets that will be converted to cash within one year. Current liabilities are those that will be paid within one year. The Statements of Net Position are prepared under the accrual basis of accounting; assets and liabilities are recognized when goods or services are provided or received despite when cash is actually exchanged.

From the data presented, readers of the statements are able to determine the assets available to continue the operations of the Foundation. They are also able to determine how much the Foundation owes vendors, lenders, and others. Net position represents the difference between the Foundation's assets and liabilities, along with the difference between deferred outflows and deferred inflows, and is one indicator of the Foundation's current financial condition.

The Statements of Net Position also indicate the availability of net position for expenditure by the Foundation. Net position is divided into three major categories. The first category, net investment in capital assets, represents the Foundation's total investment in property, plant, and equipment, net of outstanding debt obligations related to these capital assets. To the extent debt or deferred inflows of resources have been incurred but not yet expended for capital assets, such amounts are not included. The next category is restricted net position, which is sub-divided into two categories, nonexpendable and expendable. Nonexpendable restricted net position includes endowment and similar resources whose use is limited by donors or other outside sources and as a condition of the gift, the principal is to be maintained in perpetuity. The Foundation did not have any nonexpendable net position at either June 30, 2015 or 2014. Expendable restricted net position is available for expenditure by the Foundation but must be spent for purposes as determined by donors and/or external entities that have placed time or purpose restrictions on the use of the resources. The final category is unrestricted net position. Unrestricted net position is available to the Foundation for any lawful purpose of the Foundation.

The Statements of Net Position (continued)

The following table summarizes the Foundation's assets, liabilities, deferred outflows/inflows, and net position at June 30, 2015, 2014 and 2013.

Statements of Net Position

In Thousands

	2015	2014	2013
Assets:			
Current assets	$ 88	$ 47	$ 132
Non-current assets	328	284	274
Total Assets	$ 416	$ 331	$ 406
Liabilities:			
Current liabilities	$ 2	$ 9	$ 98
Non-current liabilities	-	-	79
Total Liabilities	$ 2	$ 9	$ 177
Net Position:			
Net investment in capital assets	$ 5	$ 5	$ 8
Restricted - expendable	319	267	266
Unrestricted	90	50	(45)
Total Net Position	$ 414	$ 322	$ 229

Comparison of FY 2015 to FY 2014

- Current and restricted assets increased due to increase in Cash in Bank
- Non-current assets increased due to an increase in Investments in Patents.
- Current liabilities decreased due to a decrease in Accounts Payable.
- Unrestricted Net Position increased due to a Gain on Investment in Patents.

Comparison of FY 2014 to FY 2013

- Current assets decreased primarily due to the payoff of an outstanding Research Foundation loan as well as the reduction of outstanding receivables.
- Capital Assets, Net and Invested in Capital Assets, Net decreased due to depreciation of assets.

The Statements of Net Position (continued)

- Current and noncurrent liabilities decreased due to the payoff of the outstanding loan.
- Unrestricted Net Position decreased due to the use of unrestricted resources used to pay off the above mentioned loan as well as the removal of patents from the financial statements of the Foundation.

The Statements of Revenues, Expenses, and Changes in Net Position

The Statements of Revenues, Expenses, and Changes in Net Position present the results of operations for the fiscal year. Revenues and expenses are recognized when earned or incurred, regardless of when cash is received. The statements indicate whether the Foundation's financial condition has improved or deteriorated during the fiscal year. The statements present the revenues received by the Foundation, both operating and nonoperating, and the expenses paid by the Foundation, operating and nonoperating, and any other revenues, expenses, gains, or losses received or spent by the Foundation.

Generally speaking, operating revenues are received for providing goods and services to the various customers and constituencies of the Foundation. Operating expenses are those expenses paid to acquire or produce the goods and services provided in return for the operating revenues, and to carry out the mission of the Foundation. Nonoperating revenues are revenues received for which goods and services are not provided directly to the payor.

A summary of the Foundation's revenues, expenses, and changes in net position for the year ended June 30, 2015, 2014 and 2013 follows.

Statements of Revenues, Expenses and Changes in Net Position
(in thousands)

	2015	2014	2013
Operating revenues and expenses:			
Operating revenues	$ 275	$ 263	$ 519
Operating expenses	195	163	200
Operating income	80	100	319
Nonoperating revenues and expenses:			
Gain on investment	12	1	-
Interest expense	-	(8)	(16)
Total nonoperating revenues and expenses	12	(7)	(16)
Income before other revenues, expenses, gains, or losses	92	93	313
Increase in net assets	92	93	313
Net position at beginning of year as originally reported	322	229	(84)
Net position at end of year	$ 414	$ 322	$ 229

The Statements of Revenues, Expenses, and Changes in Net Position (continued)

Comparison of FY 2015 to FY 2014

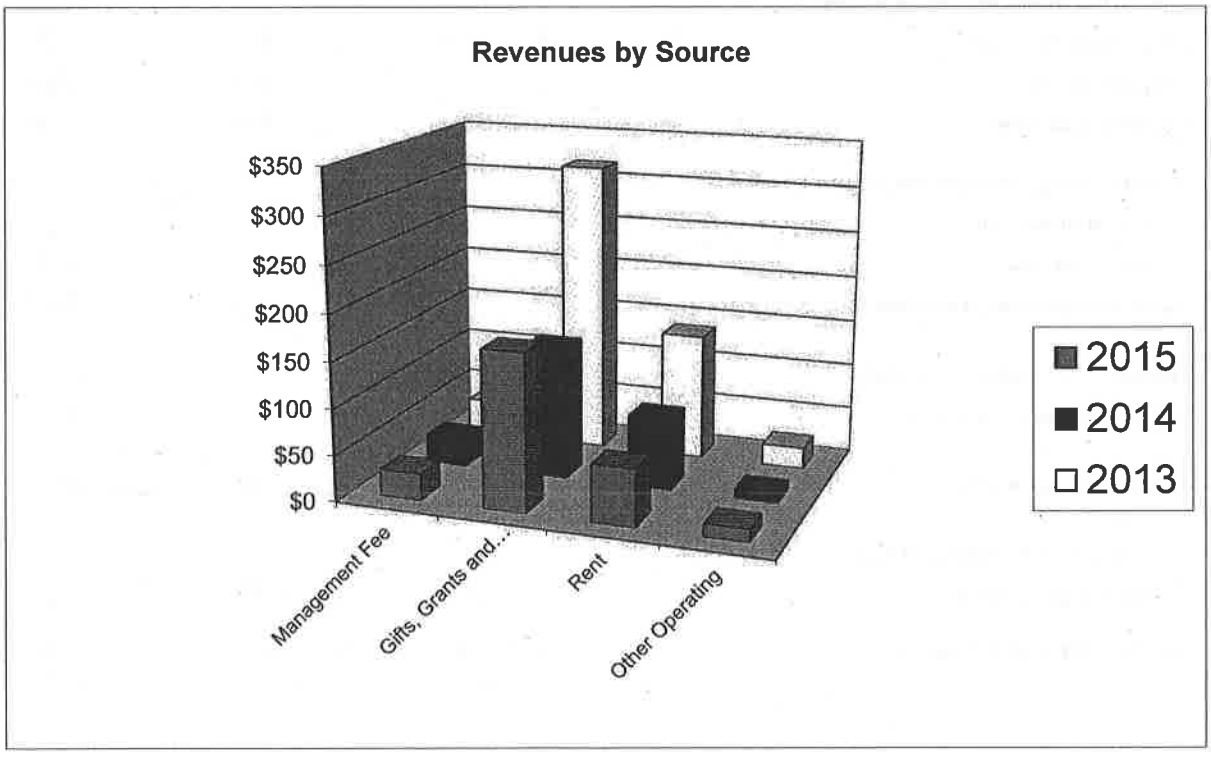
- Operating Revenue increased due to an increase in Private Grants and Contracts, Service Income, and Licensing and Royalty Income.
- Operating Expenses increased due to an increase in Payments to ETSU.
- Gain on Investment increased due to an increase in Patent Investment.

Comparison of FY 2014 to FY 2013

- Operating Revenue decreased due to reduced rent revenue as several clients graduated from the facility and a reduction in Private Grants and Contracts due to a one time large grant received in FY 2013.
- Operating Expenses decreased due to a decrease in Contractual Services.
- Nonoperating expenses decreased due to the removal of patents recorded as capital assets in FY 2013.
- Interest expense decreased due to the payoff of the loan.

Revenues

The following is a graphic illustration of revenues by source (both operating and nonoperating), which were used to fund the Foundation's operating activities for the years ended June 30, 2015, 2014 and 2013 (amounts are presented in thousands of dollars).

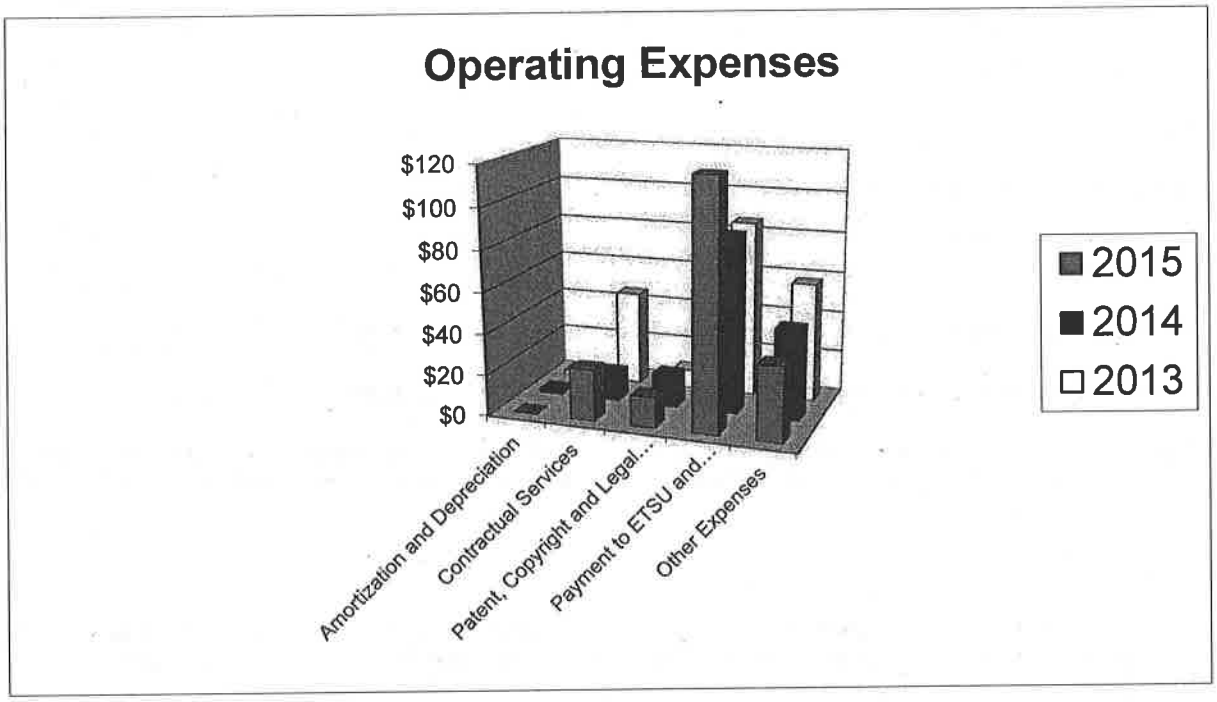


The Statements of Revenues, Expenses, and Changes in Net Position (continued)

Rent revenue is generated through the lease of space in the ETSU Innovation Laboratory that serves as a business incubator. Contractual revenue results from contracts entered into by the Foundation with private companies to provide research and other services. Management fee is the charge from the Foundation to manage the contracts.

Expenses

The following is a graphic illustration of operating expenses of the Foundation for the years ended June 30, 2015, 2014 and 2013 (amounts presented in thousands of dollars).



Payments to ETSU and ETSU Foundation represent amounts transferred to ETSU and the ETSU Foundation primarily for residual on various contracts. Contractual services represent payments under various contracts entered into by the foundation. Patent, copyright and legal services were related to services needed to receive legal rights to patents donated to the Foundation as well as application expenses related to patents being developed through businesses at the innovation center.

The Statements of Cash Flows

The Statements of Cash Flows provide information about cash receipts and cash payments during the year. This statements also assist users in assessing the Foundation's ability to generate net cash flows, its ability to meet its obligations as they come due, and its need for external financing.

Statements of Cash Flows

(in thousands)

	2015	2014	2013
Cash provided (used by:			
Operating activities	$ 53	$ 302	$ 123
Non-capital financing activities	-	(178)	(199)
Capital and related financing activities	-	-	(6)
Net increase (decrease) in cash	53	124	(82)
Cash, beginning of year	314	190	272
Cash, end of year	$ 367	$ 314	$ 190

Material sources of cash included rent proceeds, contractual revenue and management fees.

Material uses of cash were for payments to suppliers including payments to ETSU on residual contracts.

The cash position of the Foundation increased by $53,000 during FY 2014-15. The cash position of the Foundation increased by $124,000 during FY 2013-14. Collection of a $190,000 receivable from the previous year was offset by a reduction in rent collected during the year.

Capital Assets

At June 30, 2015 and 2014 the Foundation had $5,000 invested in capital assets, net of accumulated depreciation. Patents recorded as capital assets and associated accumulated amortization were removed from the financial statements as of June 30, 2013. Details of these assets are shown below.

Schedule of Capital Assets, Net of Depreciation

(in thousands of dollars)

	2015	2014	2013
Sign	$ -	$ -	$ 2
Equipment	5	5	6
	$ 5	$ 5	$ 8

The decrease in FY 2014-15 and FY 2013-14 is due to the depreciation and amortization of capital assets.

Debt

At June 30, 2014 and 2013, the Foundation had a loan payable in the amount of $-0- and $171,000 respectively as the loan was paid off during FY 14.

Economic Factors That Will Affect the Future

The Foundation is currently going through a period of transition. Several long term tenants have graduated from the facility which has resulted in reduced revenue. Staff is working with several companies and entities to recruit new businesses to the lab. The Board of Directors has continued its review of the strategic direction the Foundation should follow in the future considering the current economic climate. As the economy continues to improve and the strategic review is finalized, it is anticipated that the Foundation will be able to attract several new clients to help fulfill its mission of providing help for start-up companies.

We are not aware of any other factors, decisions, or conditions that are expected to have a significant impact on the financial position or results of operations during this fiscal year.

Requests for Information

This financial report is designed to provide a general overview of the Foundation's finances for all those with an interest in the Foundation's finances. Questions concerning any of the information provided in this report or requests for additional information should be direct to Dr. David Collins, Treasurer, P. O. Box 70601, Johnson City, TN 37614.

EAST TENNESSEE STATE UNIVERSITY RESEARCH FOUNDATION
Statements of Net Position
June 30, 2015 and 2014

	2015	2014
ASSETS		
Current Assets		
Cash and cash equivalents	$ 67,528	$ 46,866
Rent receivable	387	387
Prepaid expense	20,388	-
Total Current Assets	88,303	47,253
Non-current Assets		
Cash and cash equivalents	299,136	266,652
Investment - patents	24,121	11,845
Capital assets (net of accumulated depreciation)	4,671	5,146
Total non-current assets	327,928	283,643
Total assets	$ 416,231	$ 330,896
LIABILITIES		
Current Liabilities		
Accounts payable	$ 900	$ 4,243
Sales tax payable	14	17
Prepaid rent	188	4,300
Security deposit payable	1,254	800
Total current liabilities	$ 2,356	$ 9,360
NET POSITION		
Invested in capital assets	$ 4,671	$ 5,146
Restricted for expendable research	317,044	264,171
Restricted for expendable service	2,481	2,481
Unrestricted	89,679	49,738
Total net position	$ 413,875	$ 321,536

EAST TENNESSEE STATE UNIVERSITY RESEARCH FOUNDATION
Statements of Revenues, Expenses and Changes in Net Position
For the Years Ended June 30, 2015 and 2014

	2015	2014
Operating Revenues		
Rent	$ 61,818	$ 77,768
Management fee	29,035	31,019
Private gifts grants and contracts	169,505	144,297
Services income	8,982	6,710
Licensing and royalty income	4,824	2,369
Other income	370	304
Total operating revenue	274,534	262,467
Operating Expenses		
Professional dues	-	572
Program support	2,248	10,834
Meals and entertainment	1,117	1,386
Patent, copyright, audit and legal services	14,548	16,107
Office expense	14,883	12,664
Other expense	616	126
Payments to ETSU	118,844	86,069
Contractual services	24,658	13,972
Travel and conference	17,262	11,809
Laboratory supplies	-	6,702
Depreciation	475	2,475
Operating expenses	194,651	162,716
Operating income	79,883	99,751
Non-operating Revenue (Expense)		
Investment income	180	155
Gain on investment	12,276	595
Interest expense	-	(7,804)
Increase in net position	92,339	92,697
Net position beginning of year	321,536	228,839
Net position end of year	$ 413,875	$ 321,536

EAST TENNESSEE STATE UNIVERSITY RESEARCH FOUNDATION
Statements of Cash Flows
Years Ended June 30, 2015 and 2014

	2015	2014
Cash Flows from Operating Activities		
Rent	$ 58,160	$ 83,153
Contract revenue	169,505	338,516
Other receipts	43,210	40,402
Payments to suppliers and vendors	(217,909)	(160,642)
Net cash flows from operating activities	52,966	301,429
Cash Flows from Non-Capital Financing Activities		
Principal paid on debt	-	(170,691)
Interest paid	-	(7,804)
Net cash flows from non-capital financing activities	-	(178,495)
Cash Flows from Investing Activities		
Interest on investments	180	154
Net increase in cash and cash equivalents	53,146	123,088
Cash and cash equivalents beginning of year	313,518	190,430
Cash and cash equivalents end of year	$ 366,664	$ 313,518
Reconciliation of Net Operating Income to Net Cash Provided by Operating Activities		
Operating income	$ 79,883	$ 99,751
Adjustments to reconcile operating income to net cash		
Depreciation	475	2,475
Changes in assets and liabilities		
Accounts receivable	-	190,000
Rent receivable	-	2,128
Prepaid expenses	(20,388)	-
Due from University	-	4,219
Sales tax payable	(4,115)	3,927
Accounts payable	(3,343)	(399)
Security deposit payable	454	270
Interest payable	-	(942)
Net cash provided by operating activities	$ 52,966	$ 301,429

EAST TENNESSEE STATE UNIVERSITY RESEARCH FOUNDATION
Notes to Financial Statements
June 30, 2015 and 2014

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity - The East Tennessee State University Research Foundation (the "Foundation") is a nonprofit corporation chartered in 2002. The Foundation is operated exclusively for purposes related to the research, public service and instructional function of East Tennessee State University (the "University").

Fiscal Year-End - The Foundation operates on a fiscal year ending June 30. All references in these notes refer to the fiscal year-end unless otherwise specified.

Basis of Presentation - The financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America (GAAP) applicable to governmental colleges and universities engaged in business-type activities as prescribed by the Governmental Accounting Standards Board (GASB).

Basis of Accounting - For financial statement purposes, the Foundation follows pronouncements issued by GASB due to its relationship with the University and follows the same reporting principles as the University. The University is considered a special-purpose government engaged only in business-type activities. Accordingly, the financial statements have been prepared using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of related cash flows. Gifts and similar items are recognized as revenue as soon as all eligibility requirements imposed by the provider have been met. All significant interfund transactions have been eliminated.

Amounts reported as operating revenues include rental income, performance fees, gifts, and other sources of operating revenue. Operating expenses for the Foundation include contractual services; patent, copyright and legal services; depreciation; support to the University and other operating supplies and services.

All other activity is nonoperating in nature which includes investment income.

When both restricted and unrestricted resources are available for use, generally it is the Foundation's policy to use the restricted resources first.

Use of Estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Accordingly, actual results could differ from those estimates

Capital Assets - Capital assets are stated at cost at the date of acquisition or fair value at the date of donation in the case of gifts. Depreciation on capital assets is recorded using the straight-line method.

Cash and Cash Equivalents - The Foundation considers cash equivalents to include only cash on hand and deposits in checking and savings accounts. For purposes of the statement of cash flows, the Foundation considers all highly liquid investments with a maturity date of three months or less when purchased to be cash equivalents.

Investments - Investments consist of patents held by the Foundation in accordance with provisions of GASB 72. As an estimate of fair value these patents are valued at 5 times the royalty income generated during the year.

Net Position - The Foundation's net position is classified as follows:

Invested in Capital Assets - This represents the Foundation's total investment in capital assets, net of outstanding debt obligations (if applicable) related to those capital assets. To the extent debt has been incurred but not yet expended for capital assets, such amounts are not included as a component of invested in capital assets.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Restricted for Expendable Research and Services - Restricted expendable net position includes resources in which the Foundation is legally or contractually obligated to spend resources in accordance with restrictions imposed by external third parties. The Foundation's assets include sufficient amounts of cash and accounts receivable to cover its restricted net position for expendable research and service.

Unrestricted Net Position - Unrestricted net position represents resources that are available for transactions relating to the educational and general operations of the Foundation, and may be used at the discretion of the Foundation to meet current expenses for any purpose.

New Accounting Pronouncements - The Foundation is subject to Governmental Accounting Standards Board Statement 72, Fair Value Measurement and Application ("GASB 72"). This new statement clarifies the criteria for determining when assets should be reported as investments instead of capital assets or some other type of asset. This statement is effective for years beginning after June 15, 2015 with earlier application encouraged. The Foundation has elected to adopt this standard for the year ending June 30, 2015. See notes 4 and 8 that discuss the change in classification and valuation that occurred and the prior period adjustment recognized as a result of implementing this standard.

GASB 72 is the only new GASB statement that either became effective for the year ended June 30, 2015 or could be early implemented for the year ended June 30, 2015 that is applicable to the Foundation.

Date of Management's Review - Management has evaluated events and transactions occurring subsequent to the statement of financial position date for items that should potentially be recognized or disclosed in these financial statements. The evaluation was conducted through the date of the report, which is the date these financial statements were available to be issued.

NOTE 2 - CASH AND CASH EQUIVALENTS

Custodial credit risk is the risk that in the event of a bank failure that the Foundation's deposits may not be returned to it. The Foundation's bank deposits are maintained in a bank that participates in the Tennessee Collateral Pool for Public deposits and are considered fully insured.

At June 30, 2015 the Foundation's books showed cash and cash equivalent balances of $366,664 and the bank's balance was $367,051. These balances were $313,518 and $319,591, respectively, as of June 30, 2014

EAST TENNESSEE STATE UNIVERSITY RESEARCH FOUNDATION
Notes to Financial Statements (Continued)

NOTE 3 - CAPITAL ASSETS

At June 30, 2015, capital assets consist of the following:

	Beginning of Year	Additions	Reductions	End of Year
Capital Assets Being Depreciated:				
Sign	$ 19,995	$ -	$ -	$ 19,995
Equipment	5,700	-	-	5,700
Total	25,695	-	-	25,695
Less accumulated depreciaton	(20,549)	(475)	-	(21,024)
Capital assets, net	$ 5,146	$ (475)	$ -	$ 4,671

During the year ended June 30, 2015, $475 of depreciation was charged against operations.

At June 30, 2014, capital assets consisted of the following:

Capital Assets Being Depreciated:				
Sign	$ 19,995	$ -	$ -	$ 19,995
Equipment	5,700	-	-	5,700
Total	25,695	-	-	25,695
Less accumulated depreciaton	(18,075)	(2,474)	-	(20,549)
Capital assets, net	$ 7,620	$ (2,474)	$ -	$ 5,146

During the year ended June 30, 2014, $2,474 of depreciation was charged against operations.

NOTE 4 - PATENTS

The Research Foundation owns several patents as follows:

Patent Number	Patent Title	Licensed To
6,020,383	Cholesterol Technology	Not Licensed
6,713,459	Cardiac Tissue Technology	Not Licensed
7,670,807B2	RNA Dependent Polymerase	InGex, LLC
7,866,983	Surgical Simulator System	Guamard
7,860,563 (35%)	Cardiac Neuromodulation	Advanced Neuromodulation Systems
8,227,210B2	Expression of Principle Glucose	Not Licensed

NOTE 4 - PATENTS (Continued)

In accordance with guidance in GASB 72, it was determined these patents would be appropriately valued as an investment and fair value would be the relevant measurement for financial reporting purposes. Evaluation of royalty income produced by the entire patent rights portfolio was conducted. Royalty income for the years ended June 30, 2013 and 2014 were less than $2,500. Royalty income for year ended June 30, 2015 was less than $5,000. Due to the limited royalty income produced, it was determined that the appraised values were not appropriate for financial statement purposes because the amount of related royalty income did not support the appraised values being used as fair value. It was then determined that an estimate of the fair value of the patent rights would be more appropriate using the assumption that fair value is equal to five times the amount of the current year's royalty income.

The Foundation has various financial assets that are measured at fair value in the statements of net position using inputs from the three levels of the fair value hierarchy. A financial asset or liability classification within the hierarchy is determined based on the lowest level input that is significant to the fair value measurement. The three levels are as follows:

Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Foundation has the ability to access.

Level 2 - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specific (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future values. Furthermore, although the Foundation believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following table sets forth by level, within the fair value hierarchy, the Foundation's assets at fair value as of June 30, 2015.

	Level 1	Level 2	Level 3	Total
Patents	$ -	$ -	$ 24,121	$ 24,121

The following table sets forth by level, within the fair value hierarchy, the Foundation's assets at fair value as of June 30, 2014.

	Level 1	Level 2	Level 3	Total
Patents	$ -	$ -	$ 11,845	$ 11,845

NOTE 4 - PATENTS (Continued)

During the years ended June 30, 2015 and 2014 , the Foundations's investments in level 3 assets increased in value by $13,155 and by $595 respectively due to changes in the level of patent royalties received as follows:

	2015	2014
Patents		
Balance, beginning of year	$ 11,845	$ 11,250
Total gains recognized in the change of patent values	12,276	595
Balance, end of year	$ 24,121	$ 11,845

NOTE 5 - LONG TERM LIABILITIES

The Foundation executed a promissory note with First Tennessee Bank in the amount of $678,000 to provide matching funds for the construction of an addition to the Innovation Park Laboratory. The note was secured by patents held by the Foundation. The note had an interest rate of 6.45% and had an original maturity date of 2016. During FY 2014, the Foundation used existing resources and retired the note early.

NOTE 6 - RELATED PARTY TRANSACTIONS

The University provides a portion of the facilities and equipment used by the Foundation at no cost. In addition, certain personnel of the University provide services to the Foundation without charge.

The balances and amounts of related party transactions between the Foundation and the University as of and for the years ended June 30, 2015 and 2014 were as follows:

Included in Statements of Revenues, Expenses and Changes in Net Position		
Revenues:		
Rent	$ 4,000	$ 2,755
Management fee	770	580
Contract revenue	21,120	13,920
Total revenues from the University	$ 25,890	$ 17,255
Expenses:		
Payments to the University	$ 118,844	$ 86,069

NOTE 7 - INCOME TAX STATUS

The Foundation is a private nonprofit corporation, incorporated under the Tennessee General Corporation Act. The Foundation is exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code. The Foundation is also exempt from State of Tennessee income taxes. The Foundation evaluates its tax positions in accordance with applicable standards, has evaluated its tax positions and believes it has none that are uncertain. At June 30, 2015, the Foundation's Form 990s for preceding three years and the current year remained subject to examination by the Internal Revenue Service.

NOTE 8 - PRIOR PERIOD ADJUSTMENT

A review of the patents recorded as capital assets on the books of the Foundation was conducted during the year ended June 30, 2015. Appraised values of patents were previously recorded as patent assets in the amount of $4,904,175 and amortized over the useful lives of patents ranging from 10-15 years. During the year ended June 30, 2015, the patents were assessed in relation to GASB 72 and its clarification of what constitutes an investment. Determination was made that the patents recorded on the Foundations books should not be categorized as capital assets based on the new guidance in GASB 72. Evaluation of royalty income produced by the entire patent rights portfolio was conducted to determine if the patents should be recorded as investments. Royalty income for the years ended June 30, 2013 and 2014 were less than $2,500. Royalty income for year ended June 30, 2015 was less than $5,000. Due to the limited royalty income produced, it was determined that the Foundation's financial statements would be fairly stated by estimating patents to have a fair value of five times the royalty income generated during the year. Patents recorded as capital assets and associated amortization amounts were removed from the financial statements as of June 30, 2014. The effect of the correction on the classifications presented in the statement of net position is as follows:

	Original	Adjustment	Restated
Assets			
Current assets	$ 47,253	$ -	$ 47,253
Non-current assets	1,811,583	(1,527,940)	283,643
Total assets	$ 1,858,836	$ (1,527,940)	$ 330,896
Liabilities			
Current liabilities	$ 9,360	$ -	$ 9,360
Net Position			
Invested in capital assets	$ 1,544,931	$ (1,539,785)	$ 5,146
Restricted for expendable research	264,171	-	264,171
Restricted for expendable service	2,481	-	2,481
Unrestricted	37,893	11,845	49,738
Total net position	$ 1,849,476	$ (1,527,940)	$ 321,536

▪ Certified Public Accountants
▪ Business Advisors

p: 423.246-4062
f: 423.247-2028
w: rodefermoss.com
433 E. Center Street, P.O. Box 1818
Kingsport, TN 37662

RODEFER MOSS & CO, PLLC

Independent Auditors' Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

Board of Directors
East Tennessee State University Research Foundation
Johnson City, Tennessee

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the business-type activities of East Tennessee State University Research Foundation (the "Foundation"), as of and for the year ended June 30, 2015, and the related notes to the financial statements, and have issued our report thereon dated December 8, 2015.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Foundation's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Foundation's internal control. Accordingly, we do not express an opinion on the effectiveness of the Foundation's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. However, as described in the accompanying schedule of findings, we identified a certain deficiency in internal control that we consider to be a material weakness.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. We consider item 15-01 described in the accompany schedule of findings to be a material weakness.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Foundation's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Rodefer Moss & Co, PLLC

Kingsport, Tennessee
December 8, 2015

EAST TENNESSEE STATE UNIVERSITY RESEARCH FOUNDATION
Findings
June 30, 2015

SUMMARY OF AUDITORS' RESULTS

(a) The type of report issued on the basic financial statements: unqualified opinion.
(b) A material weakness in internal control over financial reporting disclosed by the audit of the financial statements: Yes.

FINDINGS RELATING TO THE FINANCIAL STATEMENTS REPORTED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Item 15-01

Condition: An material expenditure that covered the period beginning July 1, 2015 and ending December 31, 2015 was charged to current expense instead of as a prepaid expense that would be recognized in the subsequent fiscal year.

Recommendation: Management should review all expenditures when they are being processed for recording on the general ledger and determine whether each expenditure should be expensed currently or some or all of the expenditure should be deferred to a future period(s).

Management's response: We concur with the recommendation. Unfortunately, this transaction was missed during our normal review process. We will continue to review all expenditures at year end to ensure they are incorporated as an expense in the appropriate year.

ATTACHMENT C,
PROOF OF PUBLICATION

Publication of Intent,

Johnson City Press

Legals | Legals

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: East Tennessee Healthcare Holdings, Inc., owned by: East Tennessee Healthcare Holdings, Inc. with an ownership type of Not-for-Profit Corporation and to be managed by: Mountain States Health Alliance intends to file an application for a Certificate of Need for: the establishment of a non-residential substitution-based treatment center for opiate addiction to be located at 203 Gray Commons Circle, Johnson City (Washington County), TN 37615. The estimated project cost is $1,747,777.

The anticipated date of filing the application is: May 17th, 2016
The contact person for this project is Allison Rogers VP, Strategic Planning who may be reached at: Mountain States Health Alliance, 303 Med Tech Parkway, Suite #330, Johnson City, TN 37604, 423-302-3378

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C. A. § 68-11-1607 (c) (1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

ATTACHMENT C, NOTIFICATION

Notification of Project to Local Officials

MOUNTAIN STATES HEALTH ALLIANCE

400 N. State of Franklin Road • Johnson City, TN 37604
423-431-6111

May 17, 2016

Johnson City Mayor's Office
Attn: Mayor Clayton Stout
PO Box 2150
Johnson City, TN 37601

Dear Mayor Stout:

This letter will serve as notice (pursuant to Tennessee Code Annotated 68-111-1607(c)(9)(A)) that East Tennessee Healthcare Holdings, Inc. filed a Certificate of Need with the Tennessee Health Services and Development Agency ("HSDA") on May 17, 2016 for the establishment of a non-residential substitution-based treatment center for opiate addiction to be located at 203 Gray Commons Circle, Johnson City (Washington County), Tennessee 37615.

A copy of the Letter of Intent filed with the HSDA is attached.

If you have any questions please do not hesitate to contact me at 423-302-3378.

Sincerely,

Allison M. Rogers
Vice-President, Strategic Planning

MOUNTAIN STATES HEALTH ALLIANCE

400 N. State of Franklin Road • Johnson City, TN 37604
423-431-6111

May 17, 2016

Washington County Mayor's Office
Attn: Mayor Dan Eldridge
100 E. Main Street
Jonesborough, TN 37659

Dear Mayor Eldridge:

This letter will serve as notice (pursuant to Tennessee Code Annotated 68-111-1607(c)(9)(A)) that East Tennessee Healthcare Holdings, Inc. filed a Certificate of Need with the Tennessee Health Services and Development Agency ("HSDA") on May 17, 2016 for the establishment of a non-residential substitution-based treatment center for opiate addiction to be located at 203 Gray Commons Circle, Johnson City (Washington County), Tennessee 37615.

A copy of the Letter of Intent filed with the HSDA is attached.

If you have any questions please do not hesitate to contact me at 423-302-3378.

Sincerely,

Allison M. Rogers
Vice-President, Strategic Planning

MOUNTAIN STATES HEALTH ALLIANCE

400 N. State of Franklin Road • Johnson City, TN 37604
423-431-6111

May 17, 2016

House District 6
Attn: Representative James (Micah) Van Huss
PO Box 8662
Gray, TN 37615

Dear Representative Van Huss:

This letter will serve as notice (pursuant to Tennessee Code Annotated 68-111-1607(c)(9)(A)) that East Tennessee Healthcare Holdings, Inc. filed a Certificate of Need with the Tennessee Health Services and Development Agency ("HSDA") on May 17, 2016 for the establishment of a non-residential substitution-based treatment center for opiate addiction to be located at 203 Gray Commons Circle, Johnson City (Washington County), Tennessee 37615.

A copy of the Letter of Intent filed with the HSDA is attached.

If you have any questions please do not hesitate to contact me at 423-302-3378.

Sincerely,

Allison M. Rogers

Allison M. Rogers
Vice-President, Strategic Planning

MOUNTAIN STATES HEALTH ALLIANCE

400 N. State of Franklin Road • Johnson City, TN 37604
423-431-6111

May 17, 2016

Senate District 3
Attn: Senator Rusty Crowe
808 East 8th Avenue
Johnson City, TN 37601

Dear Senator Crowe:

This letter will serve as notice (pursuant to Tennessee Code Annotated 68-111-1607(c)(9)(A)) that East Tennessee Healthcare Holdings, Inc. filed a Certificate of Need with the Tennessee Health Services and Development Agency ("HSDA") on May 17, 2016 for the establishment of a non-residential substitution-based treatment center for opiate addiction to be located at 203 Gray Commons Circle, Johnson City (Washington County), Tennessee 37615.

A copy of the Letter of Intent filed with the HSDA is attached.

If you have any questions please do not hesitate to contact me at 423-302-3378.

Sincerely,

Allison M. Rogers
Vice-President, Strategic Planning

ATTACHMENT

Affidavit for Application

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Washington

Alan Levine, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

SIGNATURE/TITLE

Sworn to and subscribed before me this 13th day of May (Month), 2016 (Year) a Notary Public in and for the County/State of Washington / Tennessee.

NOTARY PUBLIC

My commission expires March 30 (Month/Day), 2019 (Year).

TERESA A. JACKSON STATE OF TENNESSEE NOTARY PUBLIC WASHINGTON COUNTY

Supplemental #1
-COPY-

East TN Healthcare Holdings, Inc

CN1605-021

SUPPLEMENTAL #1
May 25, 2016
10:45 a.m.

1. **Section A, Applicant Profile, Item 4**

   Please indicate the ownership structure of East Tennessee State University Research Foundation.

   Response: The East Tennessee State University Research Foundation is a 501c3 which does not have any members, but does have its own Board of Directors. The President of ETSU serves as the Chairman of the Board of Directors and as such, appoints the Board of Directors. The East Tennessee State University Research Foundation is operated exclusively for purposes related to the research, public service, and instructional functions of ETSU.

2. **Section A, Applicant Profile, Item 5**

   Please provide a brief description of Mountain States Health Alliance's expertise to operate a non-residential substitution-based treatment center for opiate addiction.

   Response:
   MSHA has a long history of providing inpatient and outpatient treatment for alcohol and drug abuse patients. Woodridge Psychiatric Hospital is the only adult, pediatric, geriatric acute care psychiatric hospital in the region treating addiction and dual diagnosis patients. Woodridge has a dedicated addiction unit with 26 beds. The hospital is on pace to treat approximately 1,400 inpatients for opioid usage this fiscal year, accounting for 28 percent of the hospital's total patient volume. MSHA employs five full-time, board-certified psychiatrists; one of whom is a certified specialist in Addiction Medicine. The Addiction Unit team also includes a veteran psychotherapist with over 25 years of experience.

   In addition to detox care, multiple, daily recovery groups are provided for the inpatient population and referral assessments are conducted for appropriate aftercare programs, including residential Intensive Outpatient Programs (IOPs) or outpatient treatment. MSHA provides 6 to 8 week IOPs for the alcohol and drug abuse patient population. There are a number of well-experienced psychiatrists, therapists, counselors and other staff at Woodridge providing services those struggling with opiate addiction.

   While MSHA does not operate a non-residential substitution-based treatment center for opiate addiction, the system has vast experience treating opiate addicted patients. This experience will be coupled with the clinical knowledge and expertise available through Frontier Health. If approved, MSHA plans to engage some external resources to supplement any knowledge gaps that exist with operating this type of clinic.

3. **Section A, Applicant Profile, Item 6**

   Please provide a fully executed Option to Lease Agreement signed by both parties.

Response: A fully executed Option to Lease Agreement, signed by Mountain States Properties, Inc and East Tennessee Healthcare Holdings, Inc. is provided in **Attachment 1**. Additionally, a technical issue was identified with the deed submitted as part of the original application. This issue has been resolved and a copy of the corrected deed is provided in **Attachment 2**.

4. **Section A, Applicant Profile, Item 13**

The applicant notes in the application by Year 3 of the proposal the applicant may contract with TennCare. Please clarify the reason why the applicant has decided not to seek a contract with TennCare MCOs in Year One and Year Two of the proposed project.

Response: The applicant plans to focus first on initiating the operations of the clinic. While the applicant intends to diligently pursue discussions with TennCare to contract directly, it is unclear how much time those negotiations may take. Therefore, to be conservative in the projections, there were no TennCare patient assumptions utilized.

It is noted buprenorphine is a medication (in certain doses) covered as a TennCare pharmacy benefit. If the applicant contracts with TennCare to provide buprenorphine treatment in a non-residential substitution-based treatment center for opiate addiction please indicate how the following would be impacted:

- *Transportation (which is a service covered to contracted TennCare providers)*
- *Daily Dosing Costs*
- *Counseling*

Response: If approved, the applicant will initiate discussions with TennCare to determine the opportunity to direct contract for buprenorphine. These discussions will include negotiations related to transportation, daily dosing costs, and counseling. It is the applicant's understanding that each of the TennCare MCO's have their own contracts to provide transportation. The applicant will explore the process to be included in these contracts. Medication dispensing, monitoring, counseling, and recovery services will be included in the daily dosing charges for private pay patients, whether they are receiving buprenorphine or methadone. It is anticipated a similar model would be explored with TennCare, though TennCare could certainly consider a different payment structure for patients receiving buprenorphine versus methadone.

If contracted with TennCare, how different would services of the applicant be from services for TennCare members who receive buprenorphine from private outpatient provider approved by the Substance Abuse and Mental Health Services Administration (SAMSHA)?

Response: The provisions of Drug Addiction Treatment Act of 2000 (DATA 2000), enabled qualifying physicians in the medical office and other appropriate settings outside the OTP system to prescribe and/or dispense Schedule III, IV, and V opioid medications

for the treatment of opioid addiction if such medications have been specifically approved by the Food and Drug Administration (FDA) for that indication. In October 2002, FDA approved two sublingual formulations of the Schedule III opioid partial agonist medication buprenorphine for the treatment of opioid addiction.

If this request is approved, the proposed OTP would obtain valid accreditation status, Substance Abuse and Mental Health Services Administration (SAMHSA) certification, and Drug Enforcement Administration (DEA) registration prior to administering or dispensing opioid drugs for the treatment of opioid addiction. As stated in 42 CFR § 8.12(i)(2), these regulations apply to "opioid agonist treatment medications that are approved by the Food and Drug Administration." Currently, these drugs are methadone and pharmaceutical products containing buprenorphine, hereafter referred to as buprenorphine. The regulations apply equally to both of these medications, with the only difference being the time and treatment requirement for unsupervised dosing. These requirements are stricter than those of private outpatient providers approved by SAMSHA.

For example, per SAMSHA's "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction: Quick Guide for Physicians Based on TIP 40," physicians providing office-based buprenorphine treatment should give patients an up-to-date listing of community referral sources such as therapy groups. It also notes "referrals to social workers and case managers are often beneficial in helping patients address legal, employment and family issues." In other words, the expectation for the office-based practice is to refer or provide information on counseling, therapy and recovery services. However the certified OTP is required to actually provide individualized treatment plans as well as the resources to meet those treatment plans within the OTP.

If approved and if the OTP is able to contract directly with Tenncare for buprenorphine, those patients would receive the same comprehensive model of care and extensive level of therapy and recovery services also provided to those who are receiving methadone. The payor source of the patient will not impact the services provided to them and all patients will receive those more robust services aimed at the ultimate goal of getting them off any medication assistance therapy.

Please note there are no longer TennCare contracted Behavioral Health Organizations. The behavioral health benefit is "carved-in" the TennCare MCO. Please revise.

Response: A revised version of page 6 is included in **Attachment 3**.

It is noted on page 31 the applicant will cover methadone for only a limited TennCare population, those enrollees who are 18 to 21 years of age". Please clarify.

Response: It is the applicant's understanding that it is the policy of TennCare to exclude coverage for methadone for adults 21 years and older. Given this clinic would only serve patients who are of at least 18 years of age, this would effectively restrict the TennCare eligible population to 18 to 20 per TennCare policy. If the applicant's understanding that

TennCare will cover methadone for those 18 to 20 years of age is incorrect, that will not change the applicant's intention to explore in earnest the potential to contract directly with TennCare for the entire adult population regardless of age. That negotiation however, will only occur if this proposed project is approved. As the outcome of that negotiation is unknown, the applicant has not included any TennCare volume in the payor mix.

5. Section B, Project Description, Item 1

The executive summary is noted. However, please list each of the following topics and provide a brief description underneath each:

- *Brief description of proposed services and equipment*
- *Ownership structure*
- *Service area*
- *Need*
- *Existing Resources*
- *Project Cost*
- *Funding*
- *Financial Feasibility, and*
- *Staffing*

Response:
Brief description of proposed services and equipment:
This application proposes to establish a non-residential substitution-based treatment center for opiate addiction within Washington County, TN.

Ownership structure:
Mountain States Health Alliance (MSHA) and East Tennessee State University (ETSU) have formed a not-for-profit corporation, East Tennessee Healthcare Holdings, Inc. (ETHHI) which will own and operate this proposed non-residential Opioid Treatment Program (OTP).

Service area:
The service area will consist of the following counties: Carter, TN; Greene, TN; Hancock, TN; Hawkins, TN; Johnson, TN; Sullivan, TN; Unicoi, TN; Washington, TN; Lee, VA; Scott, VA; and Washington, VA (including the City of Bristol).

Need:
Need is established by the lack of any non-residential clinic in the area. Patients who benefit from methadone treatment must now drive anywhere from 26 to 78 miles one way to obtain treatment. Need is further established by the extent to which opiate addiction has become a problem in the area. An estimated 29,000 people in the service area, struggle with addiction to heroin, morphine and prescription opioids.

Existing resources:
There are currently no other non-residential methadone clinics in the proposed service area and the residents of these counties do not have convenient access to treatment outside of the area.

Project cost:
The proposed project will be located at 203 Gray Commons Circle, Johnson City, TN 37615 and will occupy 7,851 square feet of existing space will be renovated to meet the needs of the clinic. The estimated project cost is $1,747,777.

Funding:

Funding for this project will be through the use of existing cash reserves of MSHA.

Financial Feasibility:

The OTP is projected to have a loss of ($326,421) on 650 patients in Year 1 and a positive bottom line of $956,425 with 1,050 patients in Year 2.

Staffing:
The proposed OTP projects 17 staff to be in place by the second full year of operation.

It is noted the applicant estimates 29,000 people in the service area struggle with addiction to heroin, morphine, and prescription opioids. However, on page 29 of the application, the application states there are approximately 29,000 people from the proposed service area defined as potentially in need of treatment or ***early intervention*** *for prescription drug abuse. Please clarify how the estimate of 29,000 was calculated and why the 29,000 estimate includes early intervention in one place in the application, but not the other.*

Response: The statement provided on page 7 of the original application is intended to reflect the minimum estimate of individuals struggling with heroin, morphine and prescription opioids. Technically the 29,000 number is based on applying the state rate of 4.56 percent of individuals who are "addicted to prescription opioids" or are engaged in "risky prescription opioid use" to the service area population. The rate was identified in the 2014 "Prescription for Success" report by the TDMHSAS. Of those who are either already addicted or are engaged in risky behaviors, the range of options to address include both treatment as well as early intervention. This is important to consider in context of the larger Center which would be focused on identifying and implementing evidenced based early intervention in conjunction with the actual medical treatment through the certified OTP.

The patient need of the proposed OTP was defined based on the actual state patient count for OTPs applied to the service area. There is a very substantial population in need of these services.

What type of activities/meetings has your organization conducted to prepare and educate the public in the service area regarding this proposed application?

Response: This application was with limited time in order to be in the same review cycle as the New Path application. There has been only limited time to prepare and educate the public in the service area regarding the proposed application. Both MSHA and ETSU have initiated those activities.

Of the estimated opiate addicted individuals in the service area in the application, how many need methadone instead of buprenorphine, and why?

Response: The applicant is not aware of any evidence-based studies that establish the portion of opiate addicted individuals who need methadone instead of buprenorphine. Per SAMSHA, patients can possibly switch from methadone to buprenorphine treatment, but because the two medications are so different, patients may not always be satisfied with the results. Studies indicate that buprenorphine is equally as effective as moderate doses of methadone. However, because buprenorphine is unlikely to be as effective as more optimal-dose methadone, it may not be the treatment of choice for patients with high levels of physical dependency.

A number of factors affect whether buprenorphine is a good choice for someone who is currently receiving methadone. Patients receiving buprenorphine can possibly be switched to methadone. The clinical determination of which is more appropriate is based on clinical judgment evaluating the patient's individual situation. It is not clear without a better understanding of the patient's level of addiction and other clinical factors to estimate what percent are appropriate for methadone instead of buprenorphine. There is a role for both in the continuum of care for opioid addiction.

Please clarify if the proposed project will treat prescription drug abusers or illegal drug abusers, or both.

Response: If approved, the proposed OTP will treat both prescription drug abusers and illegal drug abusers who are appropriate for a medically-assisted treatment option.

6. **Section B. Project Description Item II. A**

Please calculate the cost per square foot using renovation costs ($196,275) only and submit a replacement page 9 and a revised square footage and cost per square footage chart.

Response: The total construction cost will be $196,275 or $25.00 per square foot. Revised pages 9, 11, and 45 are included in **Attachment 4**.

7. **Section B. Project Description Item II. C**

The applicant discusses a treatment model that includes Frontier Health. Please provide an overview of Frontier Health including experience in treating patients in a non-residential substitution-based treatment center for opiate addiction.

Response: Frontier Health has over 50 years of experience providing mental health and substance abuse services in the region. They provide therapists who assist people with mental health, substance abuse, and co-occurring disorders through individual, group and family sessions. Annually Frontier cares for approximately 3,000 to 4,000 adults with co-occurring disorders (defined as an individual with at least one mental health disorder along with a substance abuse disorder that is co-occurring at the same time). Treatment is initiated with a clinical assessment to determine the level of services needed. Services include 24/7 crisis hot line, psychiatric, medication evaluation and case management.

Frontier is recognized as a "co-occurring enhanced provider" contracted by TDMHSAS. This recognition is for programs with a higher level of integration of substance abuse and mental health treatment and recovery services. These programs are able to provide unified and integrated substance abuse and mental health treatment and recovery to individuals who have unstable or disabling co-occurring disorders. Frontier is the only provider with this status in the Northeast Region and one of only six providers across the state. The following is profile of all the types of services provided by Frontier:

- 18 outpatient sites
- 24/7 psychiatric Crisis Stabilization Unit
- 24/7 Mobile Crisis Response Program
- 24/7 CALM Center (walk-in assessment center, 12-hour respite services)
- 2 Residential Alcohol & Drug Treatment facilities (includes detoxification)
- SAFE House Domestic Violence Shelter
- 3 DD/ID Programs for Independent Living and Vocational Rehabilitation
- 4 Psychiatric Vocational Rehabilitation Recovery Programs
- Communication Center for the Deaf and Hard of Hearing
- Runaway Shelter
- 7 Peer Support Centers
- 27 group home and supported living facilities
- 2 Coordinators at local Recovery Drug Courts (Johnson City, Kingsport)
- Coordinator at the Felony Recovery Drug Court (Kingsport)
- Regional Community Justice Program (for offenders to be released and offenders being assessed in detention)

Specific to opiate addiction, Frontier began an opioid replacement program in Virginia in 2004. The program includes three phases: induction, stabilization, and reduction. The goal is to treat persons with severe opioid dependence for 12 to 18 months with Suboxone and then taper them to a medication free recovery.

What type of services will Frontier Health provide as part of the proposed project?

Response: While Frontier does not operate a certified OTP, they do have a wide breadth of therapy and recovery services that would be extremely valuable to this patient population. Frontier's experience and resources would be a key part of the proposed certified OTP. The applicant plans to contract with Frontier for therapy/counseling staff on-site (the 5.0 FTEs identified in the projected staffing chart as licensed and unlicensed therapists). These therapists would provide therapy as well as case management recovery services focused on the patient's activities of daily living (housing, employment, and other various social needs). The provision of these services would be incorporated as part of the per day patient fee, so the patient will not incur any additional fees. Furthermore, Frontier has very well-developed and expansive Intensive Outpatient Program (IOP). If the staff determines the patient could benefit from this type of care, the patient could be seamless referred to an already existing robust program. The cost of this care would be outside the per day patient fee associated with the certified OTP. This extends the OTP's access to services in a manner which would be more limited without the Frontier therapy staff embedded in the clinic.

It is noted the applicant states the center will incorporate additional components including clinical training, community education and outreach, and research and evaluation all focusing on reducing the prevalence and prescription drug abuse in the local region. However, who will pay for these services. Also, please clarify if the $13.00 per day patient fee will subsidize these services.

Response: The Center will provide these additional components through the attainment of grants to support these activities. The Center has obtained about $2.5 million in grants that will support these efforts and approximately an additional $3.5 million of grant proposals in the review stage. It is not the intention of the applicant to utilize the $13 per day patient fee through the clinic to subsidize these additional services.

The following profiles the grants the Center has either already received or is in the process of seeking.

Grant Title	Funder	Outcome
1. Diversity Promoting Drug Abuse Research Program –R24	National Institute on Drug Abuse	Funded
2. Improving Tennessee Health Care Providers Understanding of NAS	TN Department of Health	Funded
3. Very Early Communication Intervention for Infants Born with NAS and their Mothers	ETSU Research Development Committee Grant	Funded
4. Nonmedical use of prescription stimulants among Tennessee community college students: An evaluation using the theory of planned behavior	Tennessee Board Of Regents	Funded
5. Increasing Access to Medication Assisted Treatment in Rural Primary Care Practices	Agency for Health Care Research and Quality (AHRQ)	Under Review
6. NAS Registry Development	Johnson City Junior League	Funded
7. Increasing Access and Understanding of Naloxone in Carter County	TN Department of Health and Office of Health Equity and Disparity Elimination	Funded
8. Informing Research Driven Interventions in Appalachia to Address Adverse Health Consequences Associated with Increased Opioid Injection Drug Use	Health Resources and Services Administration	Under Review
9. Carter County Drug Prevention	TN Department of Mental Health and Substance Abuse Services	Funded

8. Section B, Project Description Item III.A. (Plot Plan) and III. (B).

Please indicate the number of current parking spaces available for the proposed project and how the available parking will accommodate 650 patients in Year One.

Response: There are currently 71 parking spaces available at the proposed location. Based on Johnson City zoning requirements, the proposed OTP would need to have 10 parking spaces per 1,000 square feet which equates to approximately 79 spaces for patients. Mountain States Properties, Inc. has sufficient acreage to expand the parking lot and is ready to proceed with those plans if approved.

9. Section B, Project Description, Item IV (Floor Plan)

It is noted the applicant will use 7,851 SF of the 11,761 SF building. Please indicate what is located in the remaining 3,910 SF.

Response: There are currently MSHA-related services located in those remaining 3,910 square feet of space (one office for physician recruitment staff and one office for Synergy Laboratories staff). The long-term plan is to relocate those departments, freeing up the space to house staff for the Center, who will be involved in the provision of care, training of students, and participate in active research associated with the OTP.

10. Section C, Need, Item 1. (NRMTF, Need, 1.A)

A March 29, 2016 News release from the U.S. Department of Health and Human Services (HHS) indicated new rules allowing for a qualified and currently waivered physician to prescribe buprenorphine for up to 200 patients is under public comment for 60 days starting Wednesday, March 30, 2016. Under current regulations, after one year an approved physician may request authorization to prescribe up to a maximum of 100 patients. If adopted by HHS, please discuss the impact the 200 patient rule would have on the service area in regard to patient opioid treatment access and availability, and the impact on this proposal. Source: http://www.hhs.gov/about/news/2016/03/29/hhs-takes-steps-increase-access-opioid-use-disorder-treatment-medication-buprenorphine.html

Response: With 120 existing buprenorphine providers in the proposed service area, this would certainly extend their collective capacity. However, it is important to note, the model proposed with this project would entail much broader elements of counseling, therapy, and recovery services than currently required of the other office-based practices. As part of the certified OTP, buprenorphine services will be provided in conjunction with an intensive therapy and recovery service portfolio. The intention of this project is not to meet an unmet need associated with buprenorphine, but rather to meet the unmet need of a methadone substitution option. The addition of buprenorphine is recognition that this is a clinically valid option across the continuum of care for opiate addiction and should be provided in conjunction with a full array of counseling/therapy support that will also be provided to those patients deemed most appropriate for methadone as their substitution therapy.

The list of buprenorphine providers for the proposed service area is noted in Attachment C. Need (2). Please indicate the percentage of total service area certified buprenorphine providers in relation to the total number certified in the State of Tennessee.

Response: There are 503 unique buprenorphine certified providers in the state of Tennessee (this counts providers with multiple locations as a single provider). Correspondingly there are 117 unique buprenorphine certified providers in the proposed service area. The service area listing equates to 23 percent of the total providers in Tennessee.

11. Section C, Need, Item 1. (NRMTF, Need, 1.A)

Please clarify if the applicant will develop an individual treatment plan for each patient that includes medical, counseling, vocational, education, mental health diagnosis, and needed social services. In addition, will the individual treatment plan include the duration and frequency of each of the services listed above?

Response: Yes, in accordance with the Federal Guidelines for Opioid Treatment Programs (42 CFR § 8.12 (f) (4).), each patient accepted for treatment at an OTP shall be assessed initially and periodically by qualified personnel to determine the most appropriate combination of services and treatment for that individual. It is important to point out the development of the treatment record as well as the treatment plan is a participatory process between the clinical provider and the patient. This step helps to ensure patient engagement as that is a critical component of a successful treatment plan.

The initial assessment will include preparation of a treatment plan that includes the patient's short-term goals and the tasks the patient must perform to complete the short-term goals; the patient's requirements for education, vocational rehabilitation, and employment; and the medical, psycho- social, economic, legal, or other supportive services that a patient needs. The treatment plan will also identify the frequency with which and duration of these services are to be provided. The ongoing review and updates of this plan will reflect each patient's personal history, his or her current needs for medical, social, and psychological services, and his or her current needs for education, vocational rehabilitation, and employment services.

It is noted in Year Two the applicant project 1,050 patients and will employ 1 Licensed Clinical Social Worker and 4 master's prepared therapists. The ratio of therapist to patient equals 210:1. Is a 210:1 ratio realistic? Please clarify if the applicant will provide more group therapy than individual therapy. Also, what would be the average length of individual counseling sessions?

Response: There are two levels of care that will be provided by this team. The first is the basic case management function. This refers to support related to social needs, employment progress and other activities of daily living. Therapeutic screening questions are typically provided during a 30-minute individual session and all patients will receive this level of care. The second is outpatient therapy based on the individualized treatment plan assessment which varies based on the severity of the patient. This is typically provided during a 50-minute session but could be in a group or in an individual session. Intensive group therapy is a clinically based process that is specifically provided to create and leverage peer dynamics which can actually be more effective in some cases than individual sessions. The stimulation level is higher, there is generally more growth and development, and the participants learn more during these types of sessions. A variety of therapy techniques including cognitive, didactical, and trauma therapy may be applied. If it is appropriate for a patient to more deeply explore a specific area, than individual

therapy will be provided. There is a role for both types of therapies and both will be provided as part of the proposed OTP. While dependent on the specific patient needs, it is anticipated this ratio of therapist to patient will be appropriate.

The applicant provides a continuum of care that lists available services to address opiate addiction. Please complete the following chart indicating where those services are currently available in the proposed service area, and if the applicant will provide those services.

Response: The graphic was provided to be illustrative of the continuum of strategies to reduce opioid addiction. The following chart is an example listing of providers across the region, and is not meant to be a comprehensive list as that could be very difficult to compile.

Service	Current Provider or Agency	Location	Service will be provided by the applicant? (Yes or No)
Overdose Reversal with Naloxone	All ERs, Frontier has two in VA, EMS, ETSU partners with Carter County pharmacies for distribution to qualified recipients through a TDH grant	All ERs, Frontier CSUs (Lee and Scott), EMS sites, Carter County pharmacies	Yes
Evidence Based Drug Courts	Johnson City, Kingsport, Hawkins County	Johnson City, Kingsport, Hawkins County	No
Traditional and Medically Assisted Treatment	120 buprenorphine (MAT) Narcotics Anonymous (self-help)	Throughout region	Yes
Neonatal Abstinence syndrome: Treatment of Mother, Infant and Preventing Second Pregnancy.	Niswonger Children's Hospital, Holston Valley Medical Center	Johnson City, Kingsport	Yes
Screening, Brief Intervention and Referral to TX	ETSU Primary Care Offices (adult focus), Frontier Health (adolescent focus)	Johnson City, Kingsport, Bristol	Yes
Rx Monitoring programs and Diversion control	State of TN mandates use of Controlled Substances Monitoring Database	Statewide	Yes
Health Professions Training and Continuing Education	ETSU, Frontier Health (American Psychology Association certified continuing education program); Quillen College of Medicine	Grand Rounds; APA continuing education provided monthly in Johnson City	Yes (as part of the Center)
Dissemination & Implementation of Effective Prevention Programs.	Frontier Health (Children and Youth Division), Local Community Coalitions	Johnson City, Bristol, Greeneville, Hawkins County	Yes (as part of the Center)

The applicant notes East Tennessee University will be available to do "real time" research on actual clinical care practices for the opioid dependent population. Please discuss what "real time" research entails and how does it relate to the proposed project patient population.

Response: Practice-based research is a better description of the type of research that will be conducted as opposed to "real-time" research. Through ETSU's Center for Prescription Drug Abuse Prevention and Treatment, patient and provider-focused research will be conducted that informs best practices in opioid treatment programs. Types of projects may include evaluation of health care provider interventions on treatment outcomes, collaboration with other opioid treatment programs to conduct randomized controlled trials, qualitative evaluations of patients, and trials that examine the efficacy of different treatment approaches. While this list of potential projects is not exhaustive, the examples provide the vision for the opioid treatment program. ETSU is well positioned to conduct research described above. This aspect is one that sets the applicant apart as compared to models that do not seek to inform future treatment through the conduction of rigorous research.

On the top of page 21 the applicant notes the proposed project intends to offer two medication-assisted therapy options for it patients, methadone and buprenorphine. However, in other parts of the application the applicant notes buprenorphine will not be offered until Year 3 of the proposed project. Please clarify.

Response: The proposed OTP intends to focus first on operationalizing the methadone medication-assisted therapy option as this is the medical option not currently available in the proposed service area. With an excess of 100 buprenorphine providers in the proposed service area, this is already a medication-assisted therapy option in ample supply. However, it is important to note these providers do not offer this medication option in the same comprehensive model as proposed by the applicant. The proposed project intends to provide methadone in the first two years of operation and then expand to buprenorphine in the third year.

12. Section C, Need, Item 1. (NRMTF, Need, Assessment (Page 24))

Please clarify if data is available in the proposed service area for arrests for drug use and hospital admittance for drug use. If so, please provide.

Response: Regional and county level data for opioid related drug arrests and hospital admittance for opioid poisoning are available for the eight (8) Tennessee counties in the proposed service area. The following data are put forward by the TN Department of Mental Health and Substance Abuse Services in the Suggested Heroin Indicators: Tennessee 2015 recommendations from the State Epidemiological Outcomes Workgroup (SEOW).

Drug related arrests 2013/2014

County	Heroin related arrest rate (per 10k population)	Opioid related arrest rate (per 10k population)
Johnson	Count less than 5	25.0-55.0
Sullivan	Count less than 5	25.0-55.0
Carter	Count less than 5	10.0-15.0
Washington	.01-.50	10.0-15.0
Unicoi	Count less than 5	25.0-55.0
Hawkins	Count less than 5	25.0-55.0
Greene	.01-.50	10.0-15.0
Hancock	Count less than 5	25.0-55.0

Notes: Rates are only shown for counties where the combined count during the time period (2013/2014) was greater than 5. Rates based on two year averages. Opioids exclude heroin.
Source: Pennings J. Suggested Heroin Indicators: Tennessee 2015. Tennessee Department of Mental Health and Substance Abuse Services; 2015.

Hospital Discharge Data for drug-related poisoning 2013/2014

County	Hospital Discharges for heroin poisonings (per 10k population)	Hospital Discharges for opioid poisonings (per 10k population)
Johnson	Rate less than .01	4.6-7.4
Sullivan	Rate less than .01	7.4-9.6
Carter	Rate less than .01	7.4-9.6
Washington	Rate less than .01	4.6-7.4
Unicoi	Rate less than .01	7.4-9.6
Hawkins	Rate less than .01	9.6-12.3
Greene	Rate less than .01	9.6-12.3
Hancock	Rate less than .01	12.3-15.4

Source: Pennings J. Suggested Heroin Indicators: Tennessee 2015. Tennessee Department of Mental Health and Substance Abuse Services; 2015.

Opioid specific data for the Virginia counties of Scott, Washington, and Lee are not currently available; however, the Virginia Crime Trends report put forward by the Department of Criminal Justice Services Criminal Justice Research Center in February of 2012 compares the overall drug arrest rates in 2001 to 2010 in the service counties of Washington, Scott, and Lee.

County	2001 Drug Arrest Rate (per 100,000 population)	2010 Drug Arrest Rate (per 100,000 population)	Percent change
Washington	94.0	415.1	342% increase
Scott	149.4	566.3	279% increase
Lee	540.7	183.9	66% decrease

Source: Department of Criminal Justice Services Criminal Justice Research Center (2012). Virginia Crime Trends 2001-2010. Richmond, VA: 27.

County level data for hospital admittance in Virginia is currently only available through a formal application process. According to the Virginia Online Injury Reporting System

(VOIRS) the 2013 all types poisoning rate for all gender, race, and age in Southwest VA-Area III was 125.97 or 1,709 incidents per 1,356,632 total population. The age adjusted rate was 127.7.

An additional indicator of hospital admittance associated with prescription drug abuse is the total number of admissions to a TN, VA or NC hospital from the proposed service area with an admission code indicating opiate usage. The number totaled 3,172 admissions between October, 2014 and September, 2015 based on the data from the respective states' discharge databases (THA, VHHA, and NC state database).

13. Section C, Need, Item 1. (NRMTF, Need, 3)

What is the estimated number of persons in the proposed service area addicted to heroin or other opioid drugs and an explanation of the estimate?

Response: According to a 2014 report from the National Institute on Drug Abuse, in 2011, 4.2 million Americans aged 12 or older (or 1.6 percent) had used heroin at least once in their lives. It is estimated that about 23 percent of individuals who use heroin become dependent on it. Applying these rates to the proposed service area population indicates approximately 2,400 individuals addicted to heroin.

	2016	2020
Service Area Population	643,005	655,045
Estimated US Population Using Heroin at Least Once	1.6%	1.6%
Estimated Service Area Population Using Heroin at Least Once	10,288	10,481
Estimated US Number Becoming Addicted to Heroin	23%	23%
Estimated Service Area Population Becoming Addicted to Heroin	2,366	2,411

Source: https://www.drugabuse.gov/publications/drugfacts/heroin

Additionally, there are approximately 29,000 individuals who are "addicted to prescription opioids" or are engaged in "risky prescription opioid use" to the service area population. This estimate is based on applying the state rate of 4.56 percent of individuals was identified in the 2014 "Prescription for Success" report by the TDMHSAS.

14. Section C, Need, Item 1. (NRMTF, Need, 6)

Please indicate if the proposed 11,761 SF facility has the capacity to expand to accommodate a growing patient population. If so, how many SF can be added?

Response: The facility is located on a 38 site acre site with sufficient space to expand the building if need be. Given the significant size of the site, a substantial amount of square footage could be added. The applicant does not anticipate future growth would be inhibited at this site.

15. Section C, Need, Item 1. (NRMTF, Service Area, Page 31 and Relationship to Existing Applicable Plans (Medicare and TennCare, Page 33)

It is noted the applicant plans to explore opportunities with TennCare to contract directly to meet the needs of a broader age span for methadone. However, methadone is not a covered TennCare benefit. Please clarify.

Response: It is the applicant's understanding that it is the policy of TennCare to exclude coverage for methadone for adults 21 years and older. Given this clinic would only serve patients who are of at least 18 years of age, this would effectively restrict the TennCare eligible population to 18 to 20 per TennCare policy. If the applicant's understanding that TennCare will cover methadone for those 18 to 20 years of age is incorrect, that will not change the applicant's intention to explore in earnest the potential to contract directly with TennCare for the entire adult population regardless of age. That negotiation however, will only occur if this proposed project is approved.

16. Section C, Need, Item 1. Relationship to Existing Plans, Pages 31-32

It is noted the applicant plans to add buprenorphine as a treatment option in the third year of operation. Please complete the following chart for Year Three Projections.

Year 3	# Methadone Patients	# Buprenorphine Patients (a)	Total
	1,060	70	1,130

(a) This is based on the limit of 35 new patients per provider in their first year.

17. Section C. Need, Item 5 (Existing Clinics' Utilization)

Please complete the following table indicating the current number of patients from the proposed 8 county service area, by County, that are served by out of state bordering methadone providers. The applicant will either need to contact the providers listed below directly, or the North Carolina and Virginia State Opioid Authorities to obtain the data.

Response: The following chart has been completed based on the information available to the applicant. Neither the North Carolina nor the Virginia State Opioid Authorities track this information. The applicant utilized information provided in the publically available CON application submitted by Crossroads Treatment Centers in November, 2015 (CN-1511-048). The other clinics were contacted via telephone, only some of which would share the requested information. The information obtained is provided below.

	Carter	Greene	Hancock	Hawkins	Johnson	Sullivan	Unicoi	Washington	Total
Crossroads of Weaverville, NC	64	14	7	19	1	74	9	89	277
Crossroads of Asheville, NC	3	5	1	11	0	9	0	7	36
BHG Asheville Treatment Center, Asheville, NC	Per clinic contact, detailed county patient origin unavailable; noted 6 TN patients								
Mountain Are Recovery Center, Inc., Asheville, NC	This clinic is no longer operational; it became BHG Asheville Treatment Center								
Mountain Health Solutions, Asheville, NC	No response								
Western Carolina Treatment Center, Asheville, NC	No response								
New River Comprehensive Treatment Center, Galax, VA	0	0	0	0	0	0	0	0	0

Sources: Supplemental information provided as part of CN1511-048 on November 20, 2015; telephonic surveys.

18. Section C. Need, Item 6 (Projected Annual Utilization)

Please clarify whether existing buprenorphine providers in the service area were considered when the applicant assessed the need for this proposed project. In addition, please detail how the existence of buprenorphine providers affected the assessment of need.

Response: The application included a listing of the 120 buprenorphine providers identified through the Substance Abuse and Mental Health Services Administration (SAMSHA) website. The intention of this project is not to meet an unmet need associated with buprenorphine, but rather to meet the unmet need of a methadone substitution option. The addition of buprenorphine is recognition that this is a clinically valid option across the continuum of care for opiate addiction and should be provided in conjunction with a full array of counseling/therapy support that will also be provided to those patients deemed most appropriate for methadone as their substitution therapy.

The Projected Annual Utilization Chart by County for Year One and Year Two is noted. However, Year One incorrectly lists 1,070 patients (not 650 as listed in the Projected Data Chart). Please revise.

Response: The chart noted on page 42 of the original application projects the number of potential patients in the service area. Of this potential pool of patients, the applicant proposes to care for 650 of those in Year 1 and 1,050 in Year 2.

19. Section C, Economic Feasibility, Item 1 (Project Costs Chart)

It appears the applicant used the 10 yr. facility lease agreement in the facility line item in the Project Costs Chart in the amount of $1,031,595. However, it appears the annual lease payments multiplied by 10 years do does not equal $1,031,595. Please clarify how this figure was calculated.

Response: Per the lease agreement, the base rent amount is subject to an annual CPI increase. The $1,031,595 is based on an estimated 2 percent annual increase to reflect CPI.

The letter dated May 16, 2016 from Thomas Weems Architect is noted. However, please provide a revised letter attesting that the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the latest AIA Guidelines for Design and Construction of Hospital and Health Care Facilities

Response: The requested letter is provided in **Attachment 5** .

20. Section C, Economic Feasibility, Item 3

It is noted the applicant included the Contingency Fund in the cost per square foot of construction. Please recalculate using only construction costs and submit a replacement page.

Response: The architect and engineering fees have been removed from the cost per square foot of construction. The revised cost of construction is $25.00 per square foot. Replacement page 45 is provided in **Attachment 4**.

21. Section C, Economic Feasibility, Item 4

It is noted there is a consulting fee of $50,000 in Year One and $50,000 designated as "other" in Year Two in the Other Expenses Categories listed on page 49 of the application. However, please indicate what is included in both expense line items.

Response: The $50,000 noted as consulting for Year 1 includes expenses associated with obtaining consulting expertise to initiate the clinic's operations, establish policies and procedures, ensure appropriate compliance and obtaining the necessary certifications. The Other Expenses category includes miscellaneous expenses that will increase as the volume of the clinic increases.

22. Section C, Economic Feasibility, Item 8

It is noted any positive income will be reinvested back into the larger center after MSHA's initial capital expenses are covered to cover ongoing research and evaluation. However, please clarify why the positive income would not be earmarked for facility maintenance and improvements.

Response: If approved, the clinic's annual operating budget will include annual maintenance and any necessary improvements. Any funds above and beyond the clinic's operating budget will be reinvested into the larger Center.

23. Section C, Economic Feasibility, Item 9

It is noted the applicant will provide $78,000 of charity care in Year One and $181,125 in Year 2. Please clarify how many patients will receive charity care in Year One and Year Two.

Response: The applicant projects 5 percent of patients will be charity care. This equates to approximately 32 patients in Year 1 and 52 patients in Year 2.

24. Section C, Orderly Development, Item 3

Please complete the following table. Total compensation amounts of $1,202,310 in Year One and $1,603,080 in Year Two are from the Projected Data Chart.

Response: The following table has been completed.

Position	FTEs		Total Compensation		*Service Area Prevailing Wages
	Yr.1	Yr.2	Yr.1	Yr.2	
Medical Director	0.5	1.0	$137,250	$274,500	N/A
On-site Prescriber (a)	1.0	2.0	$170,800	$341,600	$158,883
Nurses-RNs	2.0	2.0	$122,000	$122,000	$56,370
Nurses LPN	1.0	2.0	$48,800	$97,600	$36,000
Therapist LCSW (b)	1.0	1.0	$103,700	$103,700	$53,752
Therapists (Unlicensed) (c)	3.0	4.0	$131,760	$175,680	$43,463
Clinical Pharmacist	1.0	1.0	$164,700	$164,700	$122,494
Psychiatric Nurse Practitioner (d)	1.0	1.0	$115,900	$115,900	$90,041
Program Director Operations (e)	1.0	1.0	$97,600	$97,600	$78,756
Direct Care Staff Total	10.5	14.0	$994,910	$1,395,680	
Indirect Staff Total	3.0	4.0	$207,400	$207,400	
Total	**13.5**	**17.0**	**$1,202,310**	**$1,603,080**	

Note: The Indirect Staff Total includes an office manager and a billing/scheduling manager.
Source: Tennessee Department of Labor and Workforce Development, Median (50th Percentile) provided for the following relatively comparable positions:

(a) Compared against Family and General Practitioners
(b) Compared against Social Workers – All Other
(c) Compared against Therapists – All Other
(d) Compared against Nurse Practitioner
(e) Compared against Medical and Health Services Manager

**Please compare clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.*

Please clarify the licensure level of the "On-Site Prescriber" position.

Response: The "on-site prescriber" position(s) will be a physician licensed to practice medicine in Tennessee with at least one year of documented experience in the treatment of persons addicted to alcohol or other drugs, in accordance with the Tennessee licensure regulations for a non-residential opioid treatment program.

25. Notification Requirements

The notice to the county executive of the county in which the facility is proposed to be located, the member of the House of Representatives and the Senator of the General Assembly representing the district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality is noted. However, please provide documentation, by certified mail, return receipt requested, informing such officials that an application for a non-residential substitution based treatment center for opiate addiction has been filed with the agency by the applicant."

Response: Copies of the notification letters sent in accordance with this requirement were provided in Attachment C, Notification of the original application. Copies of the return receipts verifying these notifications were properly sent via certified mail, return receipt requested, are provided in **Attachment 6**.

26. Support Letters

Please provide any letters of support from the community, government, judicial and law enforcement, physical and behavioral health care providers, and residents near the proposed facility. If possible, please include support letters from businesses that are located in the immediate area where the proposed methadone center will be located.

Response: The applicant is working to obtain letters of support and they will be submitted prior to the HSDA hearing.

27. Proof of Publication

Please submit a copy of the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent.

Response: A copy of the publication affidavit is provided in **Attachment 7**.

28. Affidavit

The affidavit signed by Alan Levine is noted. However, this individual is different from the contact person listed in the application. Please clarify.

Response: Alan Levine is the CEO of Mountain States Health Alliance. The accompanying affidavit provided in **Attachment 8** is signed by the contact person noted in the original application.

SUPPLEMENTAL #1
May 25, 2016
10:45 a.m.

ATTACHMENT 6

Certified Mail Receipts

SUPPLEMENTAL #1

206

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at *www.usps.com®*.

JONESBOROUGH, TN 37659

OFFICIAL USE

Certified Mail Fee	$3.30
Extra Services & Fees (check box, add fee as appropriate)	
☐ Return Receipt (hardcopy)	$0.00
☐ Return Receipt (electronic)	$0.00
☐ Certified Mail Restricted Delivery	$0.00
☐ Adult Signature Required	$0.00
☐ Adult Signature Restricted Delivery	$
Postage	$0.47
Total Postage and Fees	$6.47

0796 08

Postmark Here
CARROLL REECE TN 37604
MAY 17 2016
05/17/2016
USPS

Sent To: Mayor Dan Eldridge
Street and Apt. No., or PO Box No.: 100 E. Main St
City, State, ZIP+4®: Jonesborough, TN 37659

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

7015 1520 0002 0990 1204

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at *www.usps.com®*.

JOHNSON CITY, TN 37604

OFFICIAL USE

Certified Mail Fee	$3.30
Extra Services & Fees (check box, add fee as appropriate)	
☐ Return Receipt (hardcopy)	$0.00
☐ Return Receipt (electronic)	$0.00
☐ Certified Mail Restricted Delivery	$0.00
☐ Adult Signature Required	$0.00
☐ Adult Signature Restricted Delivery	$
Postage	$0.47
Total Postage and Fees	$6.47

0796 08

Postmark Here
USPS
MAY 17 2016
05/17/2016

Sent To: Mayor Clayton Stout
Street and Apt. No., or PO Box No.: PO Box 2150
City, State, ZIP+4®: Johnson City, TN 37605

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

7015 1520 0002 0990 1198

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at *www.usps.com®*.

JOHNSON CITY, TN 37601

OFFICIAL USE

Certified Mail Fee	$3.30
Extra Services & Fees (check box, add fee as appropriate)	
☐ Return Receipt (hardcopy)	$0.00
☐ Return Receipt (electronic)	$0.00
☐ Certified Mail Restricted Delivery	$0.00
☐ Adult Signature Required	$0.00
☐ Adult Signature Restricted Delivery	$
Postage	$0.47
Total Postage and Fees	$6.47

0796 08

Postmark Here
CARROLL REECE TN 37604
MAY 17 2016
05/17/2016
USPS

Sent To: Senator Rusty Crowe
Street and Apt. No., or PO Box No.: 308 East 8th Ave
City, State, ZIP+4®: Johnson City, TN 37601

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

7015 1520 0002 0990 1211

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at *www.usps.com®*.

JOHNSON CITY, TN 37761

OFFICIAL USE

Certified Mail Fee	$3.30
Extra Services & Fees (check box, add fee as appropriate)	
☐ Return Receipt (hardcopy)	$0.00
☐ Return Receipt (electronic)	$0.00
☐ Certified Mail Restricted Delivery	$0.00
☐ Adult Signature Required	$0.00
☐ Adult Signature Restricted Delivery	$
Postage	$0.47
Total Postage and Fees	$6.47

0796 08

Postmark Here
CARROLL REECE TN 37604
MAY 17 2016
05/17/2016
USPS

Sent To: Rep. James (Micah) VanHuss
Street and Apt. No., or PO Box No.: PO Box 8662
City, State, ZIP+4®: Erwin, TN 37615

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions

7015 1520 0002 0990 1228

SUPPLEMENTAL #1
May 25, 2016
10:45 a.m.

ATTACHMENT 7

Publication Affidavit

SUPPLEMENTAL #1
May 25, 2016
10:45 a.m.

JOHNSON CITY PRESS
204 W. Main Street
Johnson City, TN 37604
AFFIDAVIT OF PUBLICATION

AD# 1300913

DATES: 5-12-2016

State of Tennessee)
Carter County)
Washington County)

Teresa Hicks makes the oath that she is a Representative of The Johnson City Press, a daily newspaper published in Johnson City, in said County and State, and that the advertisement was published in said paper for 1 insertion (s) commencing on 5-12-2016 and ending on 5-12-2016.

Teresa Hicks

Sworn to and Subscribed before me this 5 12 2016
Month Day Year

CONNIE N. GUINN
STATE OF TENNESSEE
NOTARY PUBLIC
WASHINGTON COUNTY

Connie N. Guinn
Notary Public

My commission expires on 03/28/2017

This legal notice was published online at www.johnsoncitypress.com and www.publicnoticeads.com during the duration of the run dates listed. This publication fully complies with Tennessee Code Annotated 1-3-20

SUPPLEMENTAL #1
May 25, 2016
10:45 a.m.

DATES: ...

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: East Tennessee Healthcare Holdings, Inc., owned by: East Tennessee Healthcare Holdings, Inc. with an ownership type of Not-for-Profit Corporation and to be managed by: Mountain States Health Alliance intends to file an application for a Certificate of Need for: the establishment of a non-residential substitution-based treatment center for opiate addiction to be located at 203 Gray Commons Circle, Johnson City (Washington County), TN 37615. The estimated project cost is $1,747,777.

The anticipated date of filing the application is: May 17th, 2016
The contact person for this project is Allison Rogers VP, Strategic Planning who may be reached at: Mountain States Health Alliance, 303 Med Tech Parkway, Suite #330, Johnson City, TN 37604. 423-302-3378

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C. A. § 68-11-1607 (c) (1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

SUPPLEMENTAL #1
May 25, 2016
10:45 a.m.

ATTACHMENT 8

Affidavit

SUPPLEMENTAL #1
May 25, 2016
10:45 a.m.

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Washington

NAME OF FACILITY: East Tennessee Healthcare Holdings, Inc.

I, Allison Rogers, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Allison M. Rogers
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 24th day of May, 2016, witness my hand at office in the County of Washington, State of Tennessee.

Teresa Jackson
NOTARY PUBLIC

My commission expires March 30, 2019.

HF-0043

Revised 7/02

TERESA A. JACKSON
STATE OF TENNESSEE
NOTARY PUBLIC
WASHINGTON COUNTY

Supplemental #2
-COPY-

East TN Healthcare Holdings, Inc

CN1605-021

SUPPLEMENTAL #2
May 31, 2016
11:44 am

1. **Section A, Applicant Profile, Item 1**

   It is noted the lease agreement and the architect's letter both list Suite 110 as the location of the applicant. If correct, please revise the location of the applicant and submit a revised page 3.

   Response: A revised page 3 is provided in **Attachment 1.**

   The applicant indicates parking spaces will need to increase from 71 to 79 spaces if the proposed project is approved. Please clarify if the construction of the additional 8 parking spaces have been accounted for in the Project Costs Chart.

   Response: The estimated cost of the 8 additional spaces is approximately $28,000 which is accounted for in the contingency fund.

2. **Section C, Need, Item 1. (NRMTF, Need, Assessment (Page 24))**

   The charts on page 14 of the supplemental response for arrests for drug use and hospital admittance for drug use in the proposed service area are noted. However, if available, please add columns representing Tennessee and Virginia statewide data for a comparative analysis.

   Response: The Drug Related Arrests 2013/2014 for Tennessee have been added below.

Drug related arrests 2013/2014

County	Heroin related arrest rate (per 10k population)	Opioid related arrest rate (per 10k population)
Johnson	Count less than 5	25.0-55.0
Sullivan	Count less than 5	25.0-55.0
Carter	Count less than 5	10.0-15.0
Washington	.01-.50	10.0-15.0
Unicoi	Count less than 5	25.0-55.0
Hawkins	Count less than 5	25.0-55.0
Greene	.01-.50	10.0-15.0
Hancock	Count less than 5	25.0-55.0
Tennessee	1.4	12.2

Notes: Rates are only shown for counties where the combined count during the time period (2013/2014) was greater than 5. Rates based on two year averages. Opioids exclude heroin.
Source: Pennings J. Suggested Heroin Indicators: Tennessee 2015. Tennessee Department of Mental Health and Substance Abuse Services; 2015.

Hospital Discharge Data for drug-related poisoning 2013/2014

County	Hospital Discharges for heroin poisonings (per 10k population)	Hospital Discharges for opioid poisonings (per 10k population)
Johnson	Rate less than .01	4.6-7.4
Sullivan	Rate less than .01	7.4-9.6
Carter	Rate less than .01	7.4-9.6
Washington	Rate less than .01	4.6-7.4
Unicoi	Rate less than .01	7.4-9.6
Hawkins	Rate less than .01	9.6-12.3
Greene	Rate less than .01	9.6-12.3
Hancock	Rate less than .01	12.3-15.4
Tennessee	1.4	9.4

Source: Pennings J. Suggested Heroin Indicators: Tennessee 2015. Tennessee Department of Mental Health and Substance Abuse Services; 2015.

Regarding the Virginia Drug Arrest Rate trends, data have been added below.

County	2001 Drug Arrest Rate (per 100,000 population)	2010 Drug Arrest Rate (per 100,000 population)	Percent change
Washington	94.0	415.1	342% increase
Scott	149.4	566.3	279% increase
Lee	540.7	183.9	66% decrease
Virginia	447.6	492.6	10% increase

Source: Department of Criminal Justice Services Criminal Justice Research Center (2012). Virginia Crime Trends 2001-2010. Richmond, VA: 27.

According to the Virginia Online Injury Reporting System (VOIRS) the 2013 all types poisoning rate for all gender, race, and age in Virginia was 76.22 or 6,296 incidents per 8,260,405 total population. The age adjusted rate was 74.77.

An additional indicator of hospital admittance associated with prescription drug abuse is the total number of admissions to a TN, VA or NC hospital from the proposed service area with an admission code indicating opiate usage. The number totaled 3,172 admissions between October, 2014 and September, 2015 based on the data from the respective states' discharge databases (THA, VHHA, and NC state database). The corresponding numbers for the state of TN is 15,169 and for VA is 13,029.

3. Section C. Need, Item 6 (Projected Annual Utilization)

The Projected Annual Utilization Chart by County for Year One and Year Two is noted. However, the chart is confusing. Please revise and resubmit a replacement page 42 with the following chart:

County	Total Population		Total Patient Pool		Total Projected Patients	
	Yr.1 2018	Yr. 2 2019	Yr. 1 2018	Yr. 2 2019	Yr. 1 2018	Yr. 2 2019
Carter (TN)	58,274	58,328	96	96	59	94
Greene (TN)	73,075	73,620	121	121	73	119
Hancock (TN)	6,981	6,996	12	12	7	11
Hawkins (TN)	59,311	59,553	98	98	59	96
Johnson (TN)	18,952	19,032	31	31	19	31
Sullivan (TN)	159,393	159,584	263	263	160	257
Unicoi (TN)	19,003	19,082	31	31	19	31
Washington (TN)	137,400	139,160	227	230	138	224
Lee (VA)	23,194	23,194	38	38	23	37
Scott (VA)	22,287	22,283	37	37	22	36
Washington (VA)	54,795	54,818	90	90	55	88
Bristol, City, VA	15,984	15,978	26	26	16	26
Service Area Total	648,649	651,627	1,070	1,075	650	1,050

Response: The chart has been updated as requested and a revised page 42 is provided in **Attachment 2.**

4. Section C, Orderly Development, Item 3

The staffing table on page 19 of the supplemental response is noted. However, it appears the Program Director of Operations salary of $97,600 in Year One and Year Two is not included in the total in Year One and Year Two and included in the Projected Data Chart. Please clarify.

Response: The Program Director of Operations salary is included in the both the staffing table on page 19 of the supplemental response as well as the original Projected Data Chart. However, in the staffing table on page 19 of the supplemental response, the subtotal for indirect staff total was noted as 4.0 in Year 2 and it should have remained at 3.0 in Year 2. The indirect staff total includes the Program Director of Operations, an office manager and a billing/scheduling manager. There is no projected change in the number of indirect staff total. Thus the salary total for indirect staff remained constant from Year 1 to Year 2 as there is no intended change in staffing level in this category.

5. Notification Requirements

The certified mailing receipts of the notice to the county executive of the county in which the facility is proposed to be located, the member of the House of Representatives and the Senator of the General Assembly representing the district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality is noted. However, please provide a copy of the certified mail return receipt letter for each notice sent. A Certified Mail Return Receipt letter is a First Class letter that provides evidence or proof of mailing as well as evidence or proof the Certified Mail letter was delivered.

Response: Section 68-11-1607(c)(3) requires the applicant to verify the appropriate notices were sent by certified mail, return receipt requested; proof of this was provided in Attachment 6 of the supplemental responses. Once all of the receipts of delivery are returned, they will be sent under separate cover.

SUPPLEMENTAL #2
May 31, 2016
11:44 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Washington

NAME OF FACILITY: East Tennessee Healthcare Holdings, Inc.

I, ALLISON ROGERS, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Allison M. Rogers
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 27 day of May, 2016, witness my hand at office in the County of Washington, State of Tennessee.

Teresa Jackson
NOTARY PUBLIC

My commission expires March 30, 2019.

HF-0043

Revised 7/02

TERESA A. JACKSON
STATE OF TENNESSEE NOTARY PUBLIC
WASHINGTON COUNTY

Supplemental #3
-COPY-

East TN Healthcare Holdings, Inc.

CN1605-021

SUPPLEMENTAL #3
May 31, 2016
1:10 pm

1. Notification Requirements

Please use the following link, https://www.usps.com/ship/insurance-extra-services.htm to provide documentation that a certified mail return receipt letter was sent to the county executive of the county in which the facility is proposed to be located, the member of the House of Representatives and the Senator of the General Assembly representing the district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality.

Response: The requested certified mail return documentation is provided in **Attachment 1.**

SUPPLEMENTAL #3

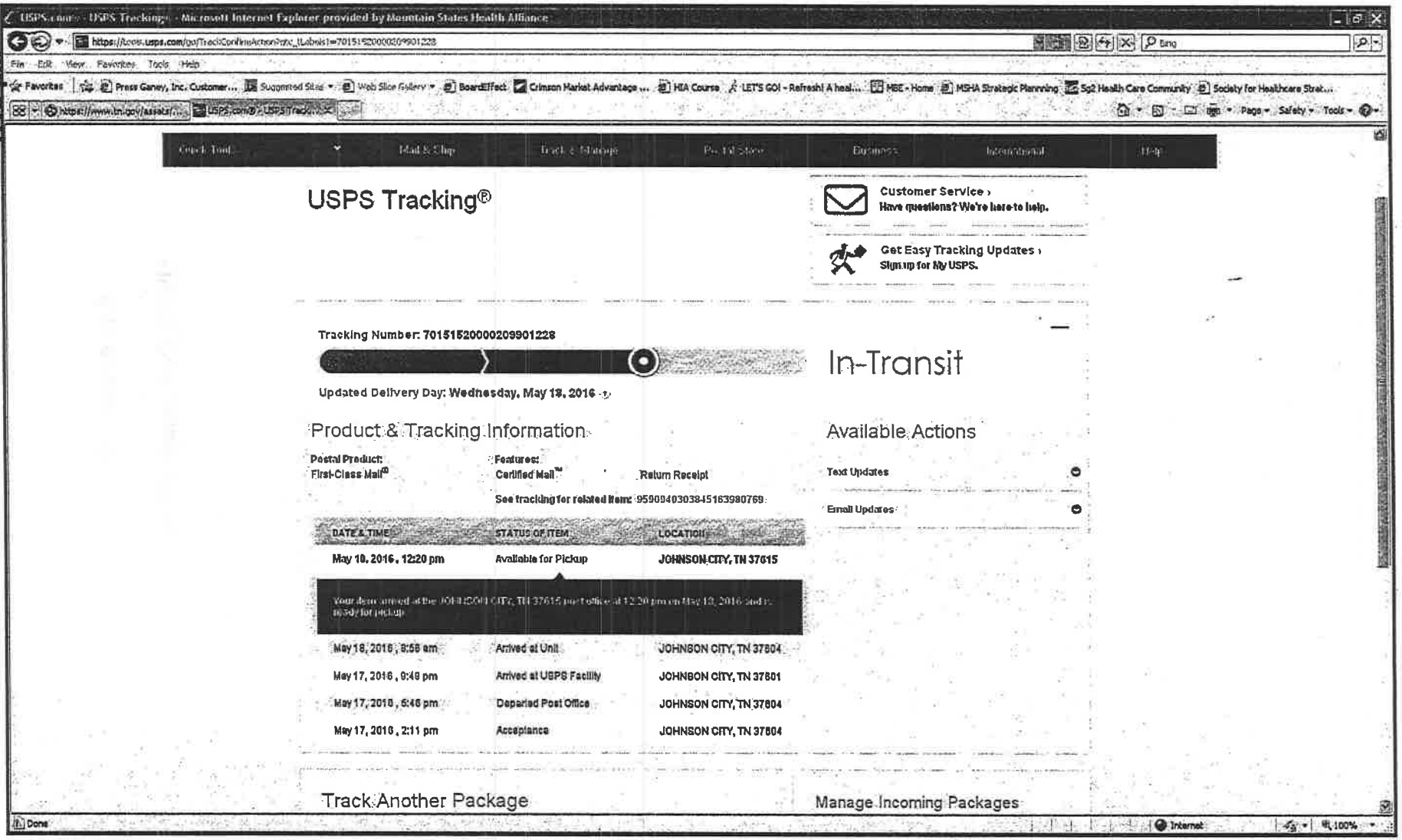
ATTACHMENT 1

USPS Documentation

SUPPLEMENTAL #3
May 31, 2016
1:10 pm

220

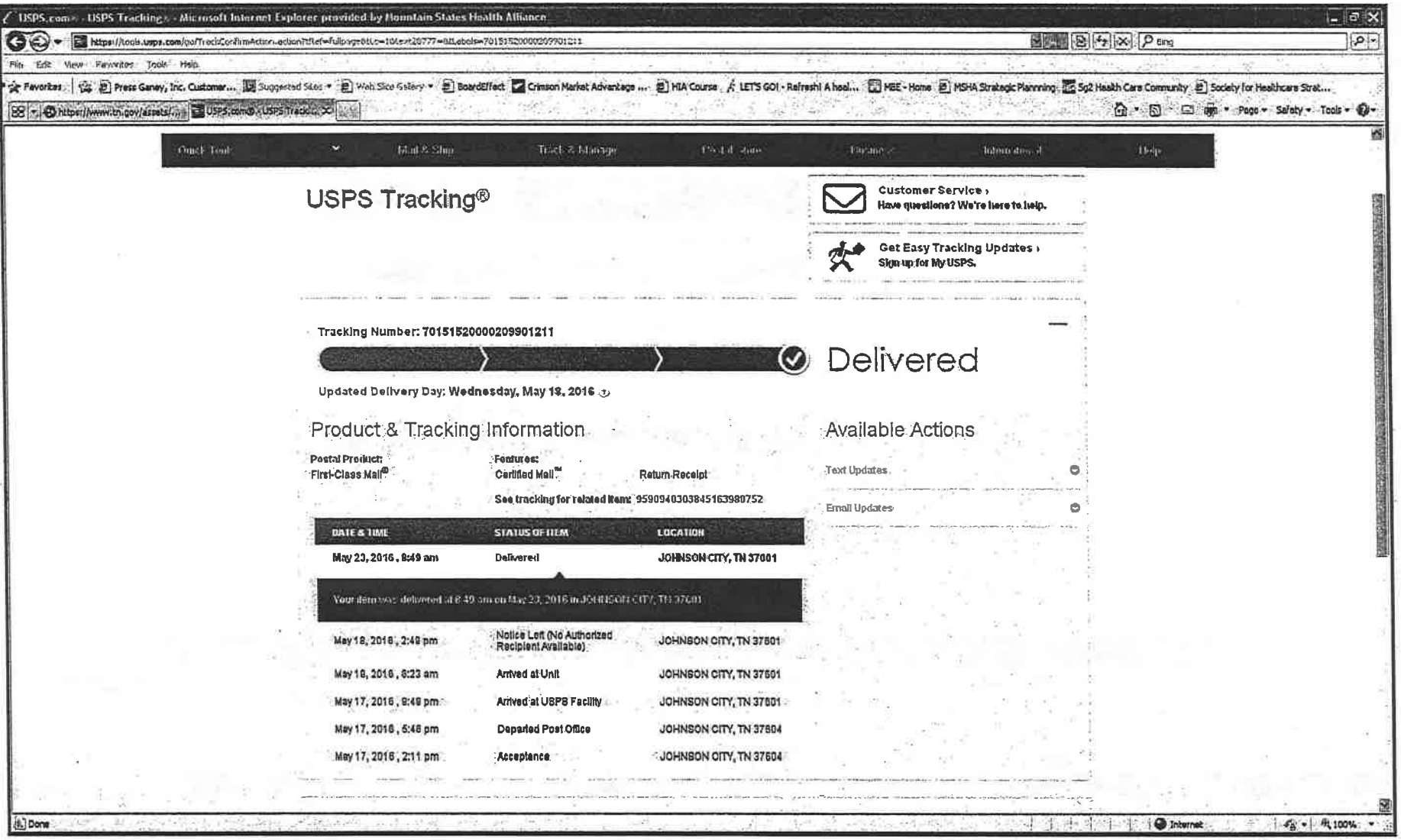
Rep. James (Micah) Van Huss
PO Box 8662
Gray, TN 37615



SUPPLEMENTAL #3
May 31, 2016
1:10 pm

221

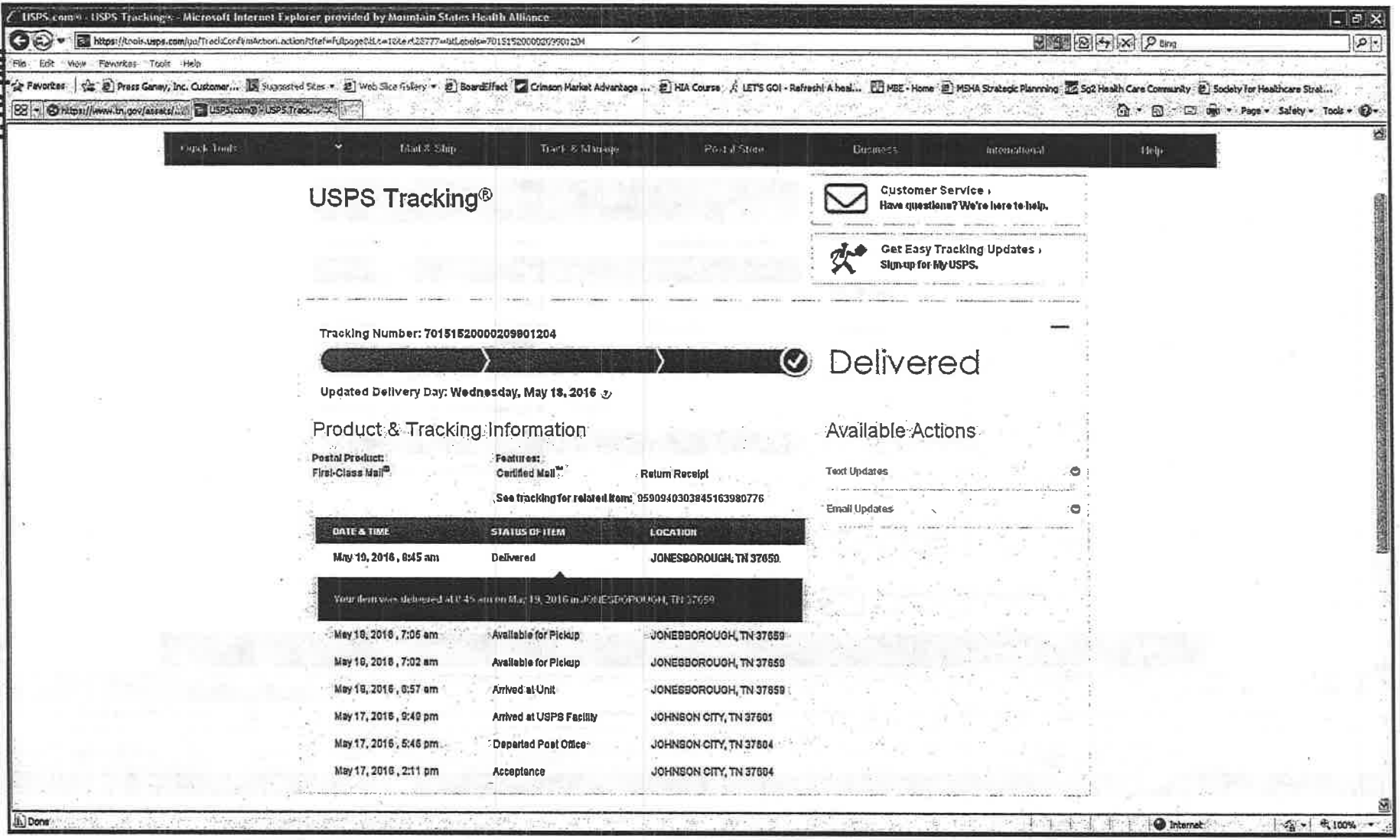
Senator Rusty Crowe
808 East 8th Avenue
Johnson City, TN 37601



SUPPLEMENTAL #3
May 31, 2016
1:10 pm

222

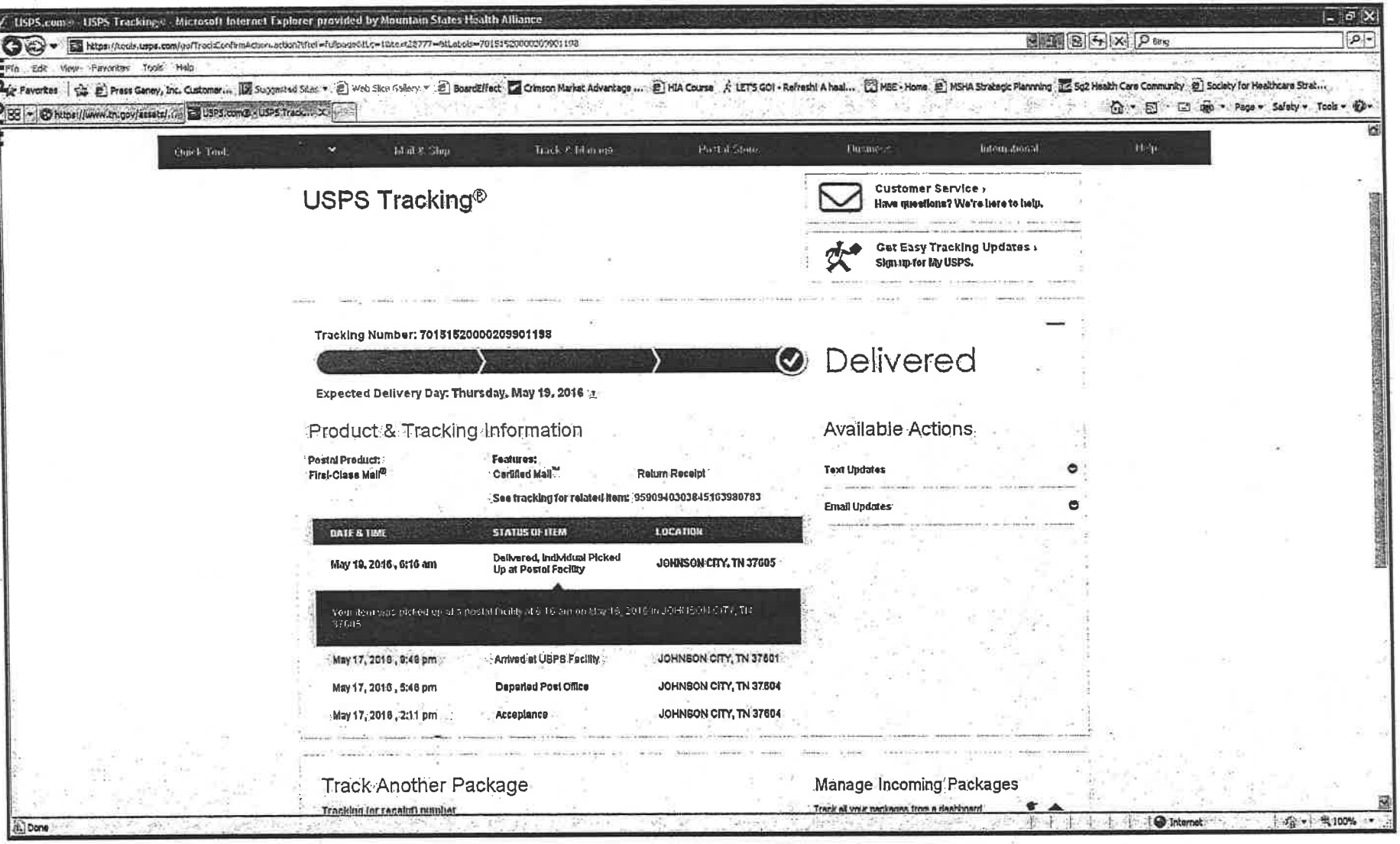
Mayor Dan Eldridge
100 E. Main Street
Jonesborough, TN 37659



SUPPLEMENTAL #3
May 31, 2016
1:10 pm

223

Mayor Clayton Stout
PO Box 2150
Johnson City, TN 37605



SUPPLEMENTAL #3
May 31, 2016
1:10 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: East Tennessee Healthcare Holdings, Inc.
CN1605-021

I, Dan H Elrod, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 31st day of May, 2016, witness my hand at office in the County of Davidson, State of Tennessee.

Lorine Foster
NOTARY PUBLIC

My commission expires Sept. 10, 2018.

LORINE FOSTER
STATE OF TENNESSEE NOTARY PUBLIC
EXPIRES SEPT. 10, 2018
DAVIDSON COUNTY

HF-0043

Revised 7/02

MOUNTAIN STATES HEALTH ALLIANCE

400 N. State of Franklin Road • Johnson City, TN 37604
423-431-6111

May 11, 2016

Ms. Melanie Hill
Health Services and Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street Nashville, TN 37243

Dear Ms. Hill:

Please find enclosed the original and two copies of East Tennessee Healthcare Holdings, Inc.'s letter of intent for the establishment of a non-residential substitution-based treatment center for opiate addiction to be located at 203 Gray Commons Circle, Johnson City (Washington County), TN 37615.

If you have any questions please do not hesitate to contact me at 423-302-3378. I look forward to working with you throughout this process.

Sincerely,

Allison M. Rogers

Allison M. Rogers
Vice-President, Strategic Planning

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Johnson City Press (Name of Newspaper) which is a newspaper of general circulation in Washington (County), Tennessee, on or before May 12th (Month / day), 2016 (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

East Tennessee Healthcare Holdings, Inc. (Name of Applicant) _____ (Facility Type-Existing)

owned by: East Tennessee Healthcare Holdings, Inc. with an ownership type of Not-for-Profit Corporation and to be managed by: Mountain States Health Alliance intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: the establishment of a non-residential substitution-based treatment center for opiate addiction to be located at 203 Gray Commons Circle, Johnson City (Washington County), TN 37615. The estimated project cost is $1,747,777.

The anticipated date of filing the application is: May 17th, 2016

The contact person for this project is Allison Rogers (Contact Name) VP, Strategic Planning (Title)

who may be reached at: Mountain States Health Alliance (Company Name) 303 Med Tech Parkway, Suite #330 (Address)

Johnson City (City)	TN (State)	37604 (Zip Code)	423/302-3378 (Area Code / Phone Number)
Allison M. Rogers (Signature)		5/11/2016 (Date)	RogersAM@msha.com (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Simpson Clinic, L.L.C.
2012 Brookside Dr., Ste. 8
Kingsport, TN 37660
Phone (423)378-5005
Fax (423)378-5070

August 10, 2016

Melanie Hill
Tennessee Health Services and Development Agency
Andrew Jackson Bldg., 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: East Tennessee Healthcare Holdings ("ETHHI"), Inc. CN1605-021

Dear Ms. Hill,

I am the President with Simpson Clinic, LLC based in Kingsport, TN. The purpose of my letter is to register support for Mountain States Health Alliance (MSHA) and East Tennessee State University (ETSU) in their bid to open an Outpatient Treatment Program to address the opioid addiction problem plaguing our community.

I support the efforts of ETSU and MSHA because they see the unique opportunity to develop a comprehensive, innovative and holistic model of care by bringing together the local academic and research resources of ETSU and the medical care expertise and capital resources of MSHA.to address these challenging issues. The Recovery-Based Treatment Program they propose will only be one component of a larger Center that will incorporate education, outreach, research, and evaluation, all aimed at making a truly significant difference in the management of the chronic disease of addiction that is having such a devastating effect in our community.

There are currently no non-residential methadone clinics in their proposed service area and the residents of these counties do not have convenient access to treatment outside of the area. This is striking when considering the following facts.

Statistics collated by the College of Public Health at ETSU put the magnitude of prescription opioid, morphine and heroin addiction in East Tennessee into perspective.

- USA is #1 in the world: The USA consumes twice as many opioids per capita than the next closest nation
- Tennessee is #2 in the #1 country: Alabama is #1 by a tenth of a point; West Virginia is a distant third
- East Tennessee is #1 in the state

We all benefit from a strong and vibrant workforce. Please help us fight opioid addiction in East Tennessee by supporting ETSU and MSHA. They have my support and I am asking for yours.

Sincerely,

Harland D. Simpson, M.D.

EASTMAN

Eastman Chemical Company
P.O. Box 1975
Kingsport, Tennessee 37662

August 1, 2016

Melanie Hill
Tennessee Health Services and Development Agency
Andrew Jackson Bldg., 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: East Tennessee Healthcare Holdings ("ETHHI"), Inc. CN1605-021

Dear Ms. Hill,

I am the Medical Director with Eastman Chemical Company based in Kingsport Tennessee. Too often I see one of my employee's or their family member's lives torn apart by the ravages of opioid addiction. It is a problem that is out of control in East Tennessee and there are currently no non-residential methadone clinics in our area and there is not convenient access to treatment outside of the area. This is striking when considering the following:

Statistics collated by the College of Public Health at East Tennessee State University (ETSU) put the magnitude of prescription opioid, morphine and heroin addiction in East Tennessee into perspective.

- USA is #1 in the world: The USA consumes twice as many opioids per capita than the next closest nation
- Tennessee is #2 in the #1 country: Alabama is #1 by a tenth of a point; West Virginia is a distant third
- East Tennessee is #1 in the state

Eastman supports community coordinated efforts that will bring a Recovery-focused and abstinence based methadone program with a unique approach by developing a comprehensive, innovative and holistic model of care. Recovery Based Clinic will incorporate education, outreach, research, and evaluation, all aimed at making a truly significant difference in the management of the chronic disease of addiction that is having such a devastating impact on our communities.

I am also among many professionals who are appalled by the alarming rate of Neonatal Abstinence Syndrome (NAS) births in our region. More than 800 infants in Tennessee were born experiencing withdrawal from addictive drugs in 2013. Over 60% of the infant's mothers were prescribed opioid painkillers, or the primary substance causing NAS, by a healthcare provider. Washington County has the 5th highest (17 per 1,000) and Sullivan County has the 6th highest (15 per 1,000) ratio of NAS/live births in the state over the 2007-2011 time period. And these alarming rates do not appear to be decreasing.

We all benefit from the health and wellbeing of our region. Please help us fight opioid addiction in East Tennessee by supporting this program and application for a Certificate of Need. Through the establishment of this type of center, we have the opportunity to establish best practices which could be replicated nationwide.

Sincerely,

Ibrahim M Heiba, MD
Medical Director
Eastman Chemical Company

May 24, 2016

Executive Director Melanie Hill
502 Deaderick St.
Andrew Jackson Building, 9th Floor
Nashville, TN 37243

Dear Executive Director Hill:

My name is David Dau. I have lived in the rural community of Gray, TN since we purchased our home in late 2008. I am writing you as not only as concerned citizen of Gray, but also as a concerned parent, father and local businessman. As you can imagine, I am concerned about the prospects of having a Methadone clinic within a 2 mile radius of my children's school, my home as well as my business.

While I recognize the need to help people with their opioid addiction, I do not feel that our rural community is the appropriate location for the following reasons I plan to expand upon.

Transit

The rural community of Gray, TN has a population of just 1885 people as of 2015 (http://www.towncharts.com/Tennessee/Demographics/Gray-CDP-TN-Demographics-data.html). As such, with the exception of a small business corridor along Highway 75, we are part of Washington County, not the much larger neighboring city of Johnson City whose population was estimated at 65,815 people as of 2014 according to the US Census website. Consequently, with such a small community population relative to Johnson City, we do not have access to readily available public transit, not only within Gray, but to/from Johnson City as well. The nearest public transit stop to Gray is Boones Creek, which is still 6.2 miles away from the proposed facility at Gray Commons. While there is the possibility that potential patients could use NetTrans, that service requires a 24hr notice and is on a first come/first served basis. I am curious to find out whether or not NetTrans has the desire to become known as the "Methadone" transit service. With any estimated volume of patients above 12 or so people, this public transit service would not be sufficient to help its original intended population, much less serve the Methadone clinic patients. According to Representative Matthew Hill, the reason that MSHA and ETSU decided on using the facility at Gray Commons was due to the proximity to Highway 26. Given the aforementioned public transit issues, that would lead us to the only conclusion that they are expecting these patients will be driving which presents its own safety issues related to the existence of a proposed Methadone Clinic in Gray.

Safety

According to the National Highway Transportation Safety Administration (NHTSA.gov), "The drug manufacturer cautions that methadone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, and that the sedative effects of the drug may be enhanced by concurrent use of other CNS depressants, including alcohol." While the ultimate goal of a Methadone Clinic in theory, is to help wean individuals off of their Opiate addiction, let us not be so naïve to forget that Methadone Clinics are basically offering drug replacement therapy. Effectively, an "illegal" drug which impairs drivers is going to be substituted with another "legally prescribed" drug which equally impairs drivers. Yes, the NHTSA's website goes on to say that European studies have shown that long term controlled use of Methadone does not impair drivers, it is also quick to point out, that concurrent use of other illicit or legal drug use in Methadone patients is common. "...in the majority of cases, patients did not exhibit stable abstinence from drug use and had an increased occurrence of simultaneous psychiatric/neurotic disorders or personality disturbances which, by themselves, could be a reason to doubt their driving ability." Is this a risk that our community leaders are really willing to accept? Do we really want many different potentially impaired drivers with differing levels of impairment driving from all the surrounding communities to Gray? Please take note that the proposed location is on a rural 2 lane road, approximately 1.5 miles from Daniel Boone high school. It

concerns me that our community leaders would consider increasing traffic volume with potentially dangerous impaired drivers on the same road as the teenage driving youth of our community, not to mention the close proximity (approx. 2mi radius) of two other elementary schools accounting for a total of 2600 of our communities brightest rising leaders of tomorrow.

Furthermore, Gray does not currently have a significant Police presence around the clock to be able to continuously monitor the increased traffic not to mention any other potential safety issues related to recovering addicts in our community. Methadone, when used in drug replacement therapy requires patients to visit the clinic daily to get their medication. As with any other overly addictive drug, it is well known that the potential for increased crime augments as a direct result of individuals needing their fix. If for some reason said individuals are unable to obtain their medication, the propensity for petty crime, theft, robbery, etc., increases so as to allow them to exchange whatever looted items for their next fix. This obviously concerns me greatly as a father of two young children, ages 5 and 7. We purchased a home in Gray due to its tranquility and inviting atmosphere. The potential negative impact this proposed clinic brings to our community is not welcome here.

In summary of the aforementioned issues, I believe the proposed clinic and corresponding Certificate of Need and rezoning should be DENIED as I believe that Gray is NOT the most appropriate location for such a facility. I believe that such a facility and patients of said facility would benefit far more greatly if the facility were located in or near the MedTech park in Johnson City. Public transit routes are available to MedTech park as well as access to other medical facilities should they be needed. Moreover, Johnson City already has significantly more police patrols in and around the MedTech park.

I also find it interesting that the proximity to Highway 26 was cited as a reason for its location at the gray commons which is approximately .7miles vs the 1mi away from Highway 26 that the MedTech corridor. Personally, I believe a much more honest answer from the interested parties at MSHA and ETSU would have been that they would like to occupy and empty building already owned by MSHA and "move the problem" as far away from the city as possible since the proximity to Highway 26 argument does not seem to hold much water.

In closing, I appreciate your time and careful consideration in this monumental task of balancing the need to helping sick people and helping the community chose the MOST appropriate location for a Methadone Clinic.

Sincerely,

David Dau
132 Walkers Bend Rd.
Gray, TN
Mobile: (276) 494-6756

Daniela Dau

Alecia L. Craighead

From: Melanie Hill
Sent: Wednesday, August 10, 2016 3:18 PM
To: Jim Christoffersen; Mark Farber; Mark Ausbrooks; Lowavia Eden
Subject: FW: Methadone Clinic in Gray TN

Melanie

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

www.tn.gov/hsda
Phone: 615-741-2364
Fax: 615-741-9884

From: Eva [mailto:liv4sun@gmail.com]
Sent: Wednesday, August 10, 2016 11:23 AM
To: Melanie Hill
Subject: Methadone Clinic in Gray TN

Please hear my plea to NOT permit ETSU and Mt. State to open a proposed meth clinic at Gray Commons in Gray, TN. My husband and I purchased a home on a quarter mile from this site two years ago, mainly because we love the rural residential area. I feel very comfortable walking the area in question with the grandchildren, even permitting them to ride their bikes in the firestation parking lot located next door to the proposed site. If this goes in, they will no longer be able to enjoy this freedom, due mainly to the traffic that will be there and we have taught our grandchildren to say NO to drugs and would not want them seeing drug addicts going in and out of the clinic. PLEASE consider the needs of our residents and children and not the needs of the drug addicts. Do not issue this certificate.

Eva Higginson
1142 Shadden Road
Gray. TN. 37615
302.299.3013
Liv4sun@gmail.com

JAMES CHRISTOFFERSEN
ANDREW JACKSON STATE OFFICE BLDG.
502 DEADERICK STREET
9TH FLOOR
NASHVILLE TN 37243

DEAR POWERS THAT RULE

MY SIMPLE QUESTION FOR YOU IS?
WHAT PART OF NO DO YOU NOT UNDERSTAND

THIS AREA IS A NICE AREA OF PEPOLE AND THEY HAVE ALREADY TOLD JOHNSON CITY THAT THEY DO NOT WANT ANEXED.

IF THE J.C. Medical AND THE ETSU GROUP WANT THIS CLINIC THEN PUT IT IN THEIR FAIR CITY. THEY WILL SOON WANT IT TO BE REMOVED

AS A RETIRED PHAMACIST AND A FORMER AIRFORCE LABORATORY OFFICER THE SUCCESS RATE FOR DRUG ADDICTION IS VERY LOW.

IF YOU HAD 25 YOUNG CHILDREN THAT HA ROTTEN TEETH IN ONE AREA WOLD YOU BUILD THEM A CANDY STORE?

JUST THINK BEFORE YOU MAKE YOUR

YOUR DECESION. WHAT REASONS DOES JOHNSON CITY & ETSU REALLY NOT WANT THE CLINIC?

GOOD LUCK TO YOUR CHOICE.

James L Reynolds
223 PEMBROOKE CIRCLE
JONESBOROUGH, TN
37659
423-262-7424

IF YOU ARE REALLY CONCERED ABOUT THE DRUG PROBLEM.
THESE ARE SOME IDEAS.

1. LIKE Indonesia DOES IF YOU ARE CAUGHT AND CONVICTED SELLING HEROIN YOU ARE EXECUTED.

2. MAKE ALL RX's BE SUBMITED IN 2 COPIES. 1 GOES TO THE PHARMACY TO BE FILED, THE 2nd COPY AFTER IS IS FILLED ~~Be sent~~ TO A DEA STATE OFFICE FOR FUTURE REVIEW IF THE PRESCRIBER IS OUT OF LINE THE MEDICAL BOARD CAN TAKE CARE LIMIT IS DAY SUPPLY NO REFILLS.

3. IF ANYONE IS CONVICED OF SELLING ADICTIVE DRUGS, 1ST TIME 1 YEAR IN PRISON, 2ND TIME 5 YEARS.

I agree THESE SUGGESTIONS WOULD BE HARD TO PUT IN PLACE WHEN SO MANY PEOPLE WANT MORE DRUGS

Alecia L. Craighead

From: Jim Christoffersen
Sent: Wednesday, August 10, 2016 3:49 PM
To: Melanie Hill; Mark Farber; Mark Ausbrooks
Subject: FW: Proposed Methadone Clinic In Gray, TN

Jim Christoffersen
General Counsel
Tennessee Health Services and Development Agency
Andrew Jackson Bldg., 9th Fl.
502 Deaderick St.
Nashville, TN 37243

(615) 741-2364

From: Jenny Christian [jennyc@christiankayaker.com]
Sent: Wednesday, August 10, 2016 3:46 PM
To: Jim Christoffersen
Subject: Proposed Methadone Clinic In Gray, TN

Dear Sir,

Please do NOT approve the Certificate of Need for the Methadone clinic proposed by MSHA and ETSU for our community.

I and many of my neighbors believe this will be a detriment to our community.We do not believe that a clinic that simply replaces one addiction with another will be of benefit to any persons and that it will potentially cause damage to them, their families, and to our community as a whole.

With the nature of this clinic and the possible number of people that would be drawn there we are concerned about safety issues, possible crime increase, potential decrease in property values, traffic issues, the proximity to schools and our local Fossil Museum and Hands On Children's Museum, lack of emergency medical services and local police force, and the lack of public transportation.

Please consider the information here: http://novusdetox.com/methadone-clinics-maintenance.php

We do believe that if MSHA and ETSU are determined to do this kind of clinic, there are options other than our community that would be better suited to their needs.

Thank you for listening!

Jenny Christian
236 Ford Creek Road
Gray, TN 37615
423.384.9280

On May 26, 2016, at 9:14 AM, Ed Champion <edchampion291@gmail.com> wrote:

Ms Hill,

According to Mr Levine from MSHA this application was rushed because New Path Treatment Center LLC had caught them by surprise with their CON submission for a center on Princeton Road in Johnson City. They felt that if the New Path CON went in first and was approved, "it would be harder for us to come back in later because there would be no more demonstrated need". This was Mr. Levine's (MSHA CEO) explanation to State Representatives Micah Van Huss and Matthew Hill as to why no public input was sought before making the CON submission.

The location proposed by ETSU/MSHA is legally in Johnson City, however it is physically located ten miles away in the rural community of Gray that is not zoned for medical service. There are three Washington County schools located within two miles of the location. The two lane highway that provides access to the facility is used by much of the traffic to and from two of those schools, Ridgeview Elementary and Daniel Boone High School. Police presence in this area is significantly less than in the medical corridor area of Johnson City proper.

The people of Gray believe the proposed location for the ETSU/MSHA clinic was not well thought out and that it should be reconsidered. Since New Path has withdrawn its application, the urgency for the ETSU/MSHA submission has been significantly reduced. If Mr. Levine and Dr. Noland (ETSU President) are unwilling to pull their CON, I request the board either turn it down because of the unsuitable location or at least send it back for further consideration.

Sincerely,

John E. Champion
A Concerned Citizen
114 Highland Hills Dr.
Gray TN 37615
423-467-9934

Dear Mr Christofferson,

We are writing in regards to the proposed Methodine clinic in Gray, TN.

As a citizen and a business owner of this great community I am very concerned about the location of this clinic. It is proposed that this clinic be opened in a very populated area, 3 area schools are within 4 miles of the location, as well as day care centers and pre-schools.

We already experience over-crowded roadways and accidents on this road. Our teenagers that are driving must drive by the proposed site on their way to school. This is not something we want our children exposed to.

The hospitals are at least 20-25 minutes away if anyone did need medical care or treatment.

There are no law enforcement agencies in this area.

We feel that this would be a very unsafe environment for our children and our community to have a clinic in our area. We work hard to keep drugs and their influence away from our school age children.

Please keep our rural community safe and help us to continue to live in a drug free environment.

Thank you for your time.

Sincerely,
Joseph & Jennie Greene

Alecia L. Craighead

From: Melanie Hill
Sent: Tuesday, July 12, 2016 10:54 AM
To: Lowavia Eden; Mark Ausbrooks
Subject: FW: Opposition to Methadone Clinic in Gray

Melanie

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

www.tn.gov/hsda
Phone: 615-741-2364
Fax: 615-741-9884

From: Mitzi Edwards [mailto:auntsis06@embarqmail.com]
Sent: Monday, June 27, 2016 1:36 PM
To: Melanie Hill
Subject: Fwd: Opposition to Methadone Clinic in Gray

Ms. Hill,
I respectfully ask that ETSU/MSHA be turned down for a Certificate of Need for this endeavor. MSHA runs over anyone in their path to ensure they get exactly what they want. I urge you to not let this request be approved. There are too many safety issues and this is a terrible idea that will put many people in danger and ruin our community.

Thank you,

Mitzi Edwards

From: "Mitzi Edwards" <auntsis06@embarqmail.com>
To: "Mitzi Edwards" <auntsis06@embarqmail.com>
Sent: Monday, May 23, 2016 9:19:23 PM
Subject: Opposition to Methadone Clinic in Gray

I am writing to you about the swift plans between ETSU/MSHA to bring a methadone clinic to Gray. This is a horrible plan that will adversely affect a rural and peaceful community. I attended the meeting in Gray last week about this. There are so many questions as to why Gray was chosen and everyone at the meeting was opposed to this. There were over 300 of us in attendance which is only a fraction of the entire body of people who are opposed.

There are so many families that have lived in this area all their lives and work hard to make the Gray/Sulphur Springs area peaceful and beautiful. I personally have lived in this particular area (Sulphur Springs) for 20 years. I am a single woman and I searched for a very long time before I bought a house in a community where I felt safe living alone. If this clinic is allowed to happen, all feelings of being safe in our area will be lost.

We have a Med Tech Corridor exactly for things like this. Why is that area not being used? MSHA is closing Crestpoint Insurance, why is that location not being used for this? Why not the land that's for sale behind Woodridge Hospital? Why choose a rural area that does not want/need a clinic when there are so many locations close to ETSU/MSHA where a clinic or rehab could be located?

Why isn't this clinic placed at ETSU or MSHA where there are adequate police patrols and emergency health care if needed? That would only be logical. If ETSU/MSHA wants this, it should be located near both. Why does a clinic even need to be in this area? I believe there are clinics in Knoxville and Asheville. *A drug addict will go to any lengths to get drugs, they should also go to any lengths to get Methodone. Things like this should be located in large cities where it's accepted that this type of institution is part of living in a larger city - not in our rural area/small city.*

From whom are ETSU and MSHA receiving funding for this? How much money do they stand to gain from this? Why are they trying to rush this through the process so quickly?

Would Dr. Noland or Mr. Levine feel comfortable having a clinic like this in their front door? They should be asked this question. Would they feel safe letting their children play outside knowing drug addicts that are probably high are driving around in their neighborhood? Would they feel safe about the drivers coming into their neighborhood? Would they mind if their property values went down?

Gray/Sulphur Springs is on an already very busy 2-lane road. Bringing extra traffic to this area, especially people that are high when they leave the clinic, is extremely dangerous. In addition, crime rates would rise because of the type of people these clinics attract. There would be people coming to that area looking to buy methadone from the people that frequent the clinic. Drug deals would be happening in our community on a frequent basis.

There are 4 schools within about 3 miles of the proposed location - Ridgeview Elementary, Gray Elementary, Daniel Boone High School, and Sulphur Springs Elementary. Our children do not need to be exposed to the type of people this would bring to our community. There is so much danger for children anyway, to bring in this clinic would be completely irresponsible from two entities that claim to want to help people.

These clinics are only out to make money. Methadone/Suboxone, etc. are only legal replacement drugs, they are not a cure. The majority of addicts going to these clinics, do not go to get “clean”. They go to obtain drugs that give them a high. Methadone has an 80% failure rate. This does nothing to solve the drug problem, it only gives drug addicts a legal option to buy their drugs. This most certainly is not a "holistic" approach to a drug problem, no matter how many times Dr. Noland professes that on tv. People aren't stupid and we don't believe everything we're told, especially when we know better and there are facts to back it up. The drug addicts aren't stupid either, they know this is the way to legally obtain drugs for their use or resale. I have a friend with a daughter addicted to drugs and her "legal" clinic drugs. Because of her “legal” drugs, her child was born addicted, the grandmother is raising the child, the daughter never stopped drugs and is pregnant again (she got pregnant the second time in between jail stints). She has made the comment that she will never stop taking the drugs she gets from the clinics as long as she lives. How are the legal drugs helping her? Does that sound like a "holistic" approach to curing drug addiction? I have empathy for the people that truly do want to get clean

and I truly believe the only way to do that is with a drug rehab clinic, certainly not a methadone clinic. And it most certainly does not need to be in Gray, a rural area.

And lastly, I have worked extremely hard for many years on one income to have a home in a safe rural area. Property values would immediately decrease if this is allowed. The people of this area have worked too hard to have our property values decline because of others and their bad choices.

I would suggest you speak with the doctor that was interviewed on camera last week at the meeting. He has received death threats against him, against his family and his family was forced to even evacuate their home and move due to drug addicts trying to get drugs. He could be a tremendous help into the insight of what we are working to avoid.

Gray doesn't want to be a city, that's why we choose to live here. We want a peaceful, low crime, safe area to live our lives and bring up our families. Gray doesn't deserve this, I respectfully ask that would you please help us stop this.

Respectfully,

Mitzi Edwards

110 Bob Walker Road

Jonesborough, TN 37659

(423) 747-3544

(423) 753-0448

crossroads treatment centers

We help opioid-dependent people get their lives back.

Ms. Melanie Hill
502 Deaderick Street
Andrew Jackson Bldg., 9th Floor
Nashville, TN 37243

August 3, 2016

Dear Ms. Hill and members of the CON Committee:

I am writing you to encourage your committee to ***deny*** the application of East Tennessee Healthcare Holdings, Inc. The application submitted has widespread community opposition and better alternatives are available.

The proposed location does not meet many of the zoning regulations, specifically road classification, parking, and zoning classification. Johnson City has spent years studying and implementing these regulations and yet the applicant has ignored these regulations when clear alternatives exist.

Not surprisingly, the community has pushed back strongly, with hundreds of residents and community leaders voicing their disapproval (see attached). Our company has followed this debate for the last decade ***and this is the biggest show of community resistance ever amassed for a proposed treatment program in the area.***

One of the applicant partners (Mountain States) has land available that meets the zoning requirements. Our company had an agreement to purchase this land and *secured City zoning approval – the first and only approval ever granted.* Mountain States sued to block the sale, and we walked away. So why hasn't Mountain States, which owns the land that has already been approved, selected this location? The reason is that Mountain States has publically stated they do not wish to commit the funds to build the facility to house the program. Our company, a fraction of the size of Mountain States, currently has 24 such facilities under development, so this seems a weak excuse, particularly given the available alternatives and community backlash.

(continued)

Ms. Melanie Hill, continued

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In prior CON applications for opioid treatment programs in the Tri-Cities area, the Committee has denied the application because "the community doesn't want it". *Community resistance has never been stronger than in this application.*

Because of this resistance and the clear alternatives that exist, I urge you to reject the application and encourage the applicant to find a more acceptable location.

Sincerely,

Rupert J. Mccormac IV, MD
Chief Executive Officer
Crossroads Treatment Centers
55 Beattie Place, Suite 810
Greenville, SC 29601

864.527.3145

c:
Mr. Clayton Stout, Mayor, Johnson City, TN
Mr. Dan Eldridge, Mayor, Washington County, TN

From the Johnson City Press:

Residents express displeasure during Gray methadone clinic meeting

Zach Vance • Updated Jul 8, 2016 at 12:55 AM

zvance@johnsoncitypress.com

Pamela Davis made it clear she had a long list of questions when she stepped to the lectern Thursday during a community meeting focused on the proposed site of an addiction treatment center in Gray.

"Why don't we just get (all the questions) and then we'll try to address them. It's a long list, I can see it from here," moderator Hank Carr said as the crowd laughed and a line of people stood behind Davis awaiting their turn to speak.

But only the first one mattered for the rest of them to be significant.

"Is your mind made up (about the location) or do we have a voice?" Davis asked to the panel — made up of East Tennessee State University President Brian Noland, Mountain States Health Alliance CEO Alan Levine and Dr. Robert Pack, the executive director of ETSU's Center of Prescription Drug Abuse Prevention and Treatment.

"That's the biggest question because I'll tell you right now, if (Gray residents) voice does not matter, these questions don't matter," Davis said following another roar from the crowd.

From our partners: How do we stop doctors, hospitals from overprescribing?

Nearly 200 people gathered inside the Appalachian Fairgrounds Home and Garden Building to voice their concern, whether it was about the site's location, opposition to methadone treatment or to show support for the initiative.

But one thing was clear, the Tri-Cities and East Tennessee have an addiction problem.

Levine said that, shortly after the announcement of the clinic, he met with city and state officials who asked if Mountain States would be willing to look at another location.

"And I said, 'Yes we would,' " he told the crowd.

But then Levine described the variables involved in finding a suitable site that met zoning requirements, such as parking and square footage.

As Levine stepped to the microphone shortly after the meeting began, most of his statements were met with shouting from disgruntled residents.

Carr had to quiet the crowd several times as they questioned many of Levine's statements.

Many asked how methadone would be distributed through the clinic and how safe it would be for someone on methadone to drive shortly after taking their dose.

Other residents asked if methadone would be sent home to patients where it could be distributed.

Levine said methadone distribution would be monitored very closely and a security team would observe the parking lot for illegal activities.

Capt. Don Jones of the Knoxville Police Department said crime has not increased around the two methadone clinics in his city, a concern posed frequently by the crowd.

State Rep. Micah Van Huss and Rep. Matthew Hill were both in attendance to support those against the site.

"We can't ignore what's going around us," Van Huss said.

"We can't continue to ignore it, but at the same time for this solution to truly be effective, we got to make sure that the community accepts what is being done and the location is a big piece of that. And clearly the residents of Gray have spoken."

"We're not opposed to getting help (for addiction), we're just opposed to this location," Hill added.

"(Dr. Noland and Levine) had expressed to both Micah and myself that they would be willing to hold the meeting anyway. It just so happens that it meets the (zoning) requirement. I think (this meeting) shows that Dr. Noland and Mountain States is committed to the community even if they have this disagreement. But we really have to synthesize this down and get to the real point, which is the location."

Dr. Tim Smyth, an addiction physician based in Johnson City, was one of the few at the meeting to support the partnership's initiative and the location.

Smyth said the site location is ideal for those seeking treatment in other areas of the Tri-Cities, like Bristol and Kingsport.

The Johnson City Board of Zoning Appeals will vote on the whether to rezone the site on Tuesday before it goes to the Johnson City Commission.

Levine and Noland declined to speak to reporters after the meeting.

Alecia L. Craighead

From:	Jim Christoffersen
Sent:	Wednesday, August 10, 2016 3:01 PM
To:	Melanie Hill; Mark Farber
Cc:	Mark Ausbrooks
Subject:	FW: Methadone - Johnson City
Attachments:	Gray clinic rezone moves forward.pdf

Jim Christoffersen
General Counsel
Tennessee Health Services and Development Agency
Andrew Jackson Bldg., 9th Fl.
502 Deaderick St.
Nashville, TN 37243

(615) 741-2364

From: Lisa May [lisa@hbm-lawfirm.com]
Sent: Wednesday, August 10, 2016 11:44 AM
To: Jim Christoffersen
Subject: Methadone - Johnson City

Jim:

It was my intention to attend your event last Friday and, if nothing else, say hello. But, on Thursday I ended up in the hospital with emergency surgery for an appendectomy that included some complications so I was not released until Monday afternoon. I have attached our morning news article regarding last night's Planning Commission meeting – a 4 hour plus affair.

Just so that you are aware of the timeline of events, Mountain States will be before the City Commission for its first reading (not a public hearing) seeking its rezoning approval on Thursday, August 18th. A total of three readings is required, the second reading being a public hearing which, I assume, will occur on September 1st and a final reading on September 15th.

It is my understanding that Mountain States' CON is still scheduled before the HSDA on August 24th and so I wanted to make sure you were not caught unaware of unfolding events in Johnson City.

Finally, if a CON is granted, then Mountain States would next appear before the City's Board of Zoning Appeals for an approval of the clinic as a "special exception". Even though the phrase "special exception" connotes a measure of discretion, it is really not a discretionary decision making process. The City Commission has set in stone certain criteria – parking for example – for the BZA to go down a checklist to make sure the property is in compliance. If rezoned to MS-1, the property easily meets the established

criteria. The one little piece of discretion the BZA has that is ill defined is perhaps "buffering", perhaps fencing, but if the BZA attempts to be too heavy handed I might have to cross that bridge to establish a brighter line.

I hope this information is helpful as you prepare for your own hearing. Whether the City wants me to come to Nashville, I am not sure. I think the City's position, while not explicit, will be evident based on the rezoning hearing of August 18th. I have not wanted the City Commission or staff to be advocates for "the project" itself while we have an objective decision making process underway i.e. land use. So, I am unsure what the City will want to do "mid-stream" of our process when Mountain States is in your arena.

Best regards,

Erick H.

Lisa May
Legal Assistant to K. Erickson Herrin, Esq.
HERRIN, BOOZE & McPEAK
P. O. Box 629
515 East Unaka Avenue
Johnson City, TN 37605-0629
Phone: (423) 929-7113
Fax: (423) 929-7114
Email: lisa@hbm-lawfirm.com

Alecia L. Craighead

From: Melanie Hill
Sent: Wednesday, August 10, 2016 3:56 PM
To: Lowavia Eden
Subject: FW: Proposed Methadone Clinic In Gray, TN

Melanie

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

www.tn.gov/hsda
Phone: 615-741-2364
Fax: 615-741-9884

From: Jim Christoffersen
Sent: Wednesday, August 10, 2016 3:49 PM
To: Melanie Hill; Mark Farber; Mark Ausbrooks
Subject: FW: Proposed Methadone Clinic In Gray, TN

Jim Christoffersen
General Counsel
Tennessee Health Services and Development Agency
Andrew Jackson Bldg., 9th Fl.
502 Deaderick St.
Nashville, TN 37243

(615) 741-2364

From: Jenny Christian [jennyc@christiankayaker.com]
Sent: Wednesday, August 10, 2016 3:46 PM
To: Jim Christoffersen
Subject: Proposed Methadone Clinic In Gray, TN

Dear Sir,

Please do NOT approve the Certificate of Need for the Methadone clinic proposed by MSHA and ETSU for our community.

I and many of my neighbors believe this will be a detriment to our community.We do not believe that a clinic that simply replaces one addiction with another will be of benefit to any persons and that it will potentially cause damage to them, their families, and to our community as a whole.

With the nature of this clinic and the possible number of people that would be drawn there we are concerned about safety issues, possible crime increase, potential decrease in property values, traffic issues, the proximity to schools and our local Fossil Museum and Hands On Children's Museum, lack of emergency medical services and local police force, and the lack of public transportation.

Please consider the information here: http://novusdetox.com/methadone-clinics-maintenance.php

We do believe that if MSHA and ETSU are determined to do this kind of clinic, there are options other than our community that would be better suited to their needs.

Thank you for listening!

Jenny Christian
236 Ford Creek Road
Gray, TN 37615
423.384.9280

RULES
OF
HEALTH SERVICES AND DEVELOPMENT AGENCY

CHAPTER 0720-11
CERTIFICATE OF NEED PROGRAM – GENERAL CRITERIA

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0720-11-.01 GENERAL CRITERIA FOR CERTIFICATE OF NEED. The Agency will consider the following general criteria in determining whether an application for a certificate of need should be granted:

(1) Need. The health care needed in the area to be served may be evaluated upon the following factors:

(a) The relationship of the proposal to any existing applicable plans;

(b) The population served by the proposal;

(c) The existing or certified services or institutions in the area;

(d) The reasonableness of the service area;

(e) The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants, and low-income groups;

(f) Comparison of utilization/occupancy trends and services offered by other area providers;

(g) The extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet these needs.

(2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:

(a) Whether adequate funds are available to the applicant to complete the project;

(b) The reasonableness of the proposed project costs;

(c) Anticipated revenue from the proposed project and the impact on existing patient charges;

(d) Participation in state/federal revenue programs;

(e) Alternatives considered; and

(f) The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.

(3) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective health care system may be evaluated upon the following factors:

(Rule 0720-11-.01, continued)

(a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);

(b) The positive or negative effects attributed to duplication or competition;

(c) The availability and accessibility of human resources required by the proposal, including consumers and related providers;

(d) The quality of the proposed project in relation to applicable governmental or professional standards.

(4) Applications for Change of Site. When considering a certificate of need application which is limited to a request for a change of site for a proposed new health care institution, The Agency may consider, in addition to the foregoing factors, the following factors:

(a) Need. The applicant should show the proposed new site will serve the health care needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change to the proposed new site.

(b) Economic factors. The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.

(c) Contribution to the orderly development of health care facilities and/or services. The applicant should address any potential delays that would be caused by the proposed change of site, and show that any such delays are outweighed by the benefit that will be gained from the change of site by the population to be served.

(5) Certificate of need conditions. In accordance with T.C.A. § 68-11-1609, The Agency, in its discretion, may place such conditions upon a certificate of need it deems appropriate and enforceable to meet the applicable criteria as defined in statute and in these rules.

Authority: *T.C.A. §§ 4-5-202, 68-11-1605, and 68-11-1609.* ***Administrative History:*** *Original rule filed August 31, 2005; effective November 14, 2005.*

CERTIFICATE OF NEED REVIEW REPORT
CN1605-021 East Tennessee Healthcare Holding, Inc.
Submitted by
Mountain States Health Alliance
303 Med Tech Parkway, Suite 330
Johnson City, TN 37604

Application date June 1, 2016

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) has reviewed the application for a Certificate of Need (CON) submitted by Mountain States Health Alliance for a non-residential (outpatient) opioid treatment program (for adult patients who are addicted to/dependent on opioid substances) to be owned by East Tennessee Healthcare Holdings, Inc. and located in Johnson City, Tennessee, Washington County. In accordance with rules of the Tennessee Health Services Development Agency (HSDA), the Department's analysis consists of the following three components: Need, Economic Feasibility, and Contribution to the Orderly Development of Health Care.

This review consists of three (3) parts:

- Scope of Project
- Analysis of Need, Economic Feasibility and Contribution to the Orderly Development of Health Care
- Conclusions

SCOPE OF PROJECT

The Mountain States Health Alliance (MSHA) and East Tennessee State University (ETSU) have formed a not-for-profit corporation, East Tennessee Healthcare Holdings, Inc. (ETHHI). ETHHI is requesting approval of a Certificate of Need for a non-residential (outpatient) substitution-based treatment program (OTP) for adult patients who are addicted to/dependent on opiates. The proposed location is 203 Gray Commons Circle, Johnson City, TN in approximately 7,851 square feet of medical office space to be redesigned for an opioid treatment program. The site is owned by Mountain States Properties, Inc. and was previously leased to MSHA's medical management group for a family practice and urgent care. Locating the proposed OTP at this site would require re-zoning.

The site is approximately 1 mile west from exit 13 of 1-26 on TN-75 S. Bobby Hicks Highway/Suncrest Drive. The Gray Commons commercial development includes 38.8 acres of developable land (MSHA owns 36.2 acres and the City of Johnson City owns 2.6 acres). The only other lot developed to date is occupied by Johnson City Fire Station 8 in a lot across the street from the proposed program site. Gray Commons is otherwise surrounded by vacant land. Daniel Boone High School is located approximately 1.5 miles further west on TN-75/Suncrest Drive. The estimate renovation cost of $1,747,777 is to be paid from MSHA cash reserves.

The proposed service area includes eight Tennessee counties corresponding to the TDMHSAS Planning Region I (Carter, Greene, Hancock, Johnson, Sullivan, Unicoi and Washington counties), three Virginia counties (Lee, Scott and Washington) and the locality of Bristol City, VA. The OTP is described as being one component of ETSU's Center for Prescription Drug Abuse Prevention and Treatment (pp. 8, 13 initial application). The applicant describes the ETHHI strategy as combining clinically valid treatment options with comprehensive services including counseling and support services (e.g. facilitating employment and housing). The applicant indicates that the Center will also provide clinical training, community education and outreach, and practical research and evaluation funded by grants awarded to ETSU. The applicant intends to partner with Frontier Health for therapy and recovery services to augment the opioid replacement services provided by the OTP, and the applicant intends to contract directly with Frontier for 5.0 FTEs of licensed and unlicensed therapists to provide on-site counseling and smooth the referral process for additional Frontier co-occurring services (see Working Relationships with Existing Health Care Providers, p. 8, below).

The OTP intends to focus on implementing operations for methadone replacement treatment during the first two years of operation and estimates that the use of buprenorphine would be implemented on a case-by-case basis as clinically indicated beginning in the third year. The applicant estimates serving 650 patients in the first year and 1,050 patients the second year. The cost of the service will be $13 per patient per day. The applicant estimates operating at a loss of $326,421 in the first year and a positive bottom line of $956,425 the second year.
The proposed OTP will have operating hours Monday through Friday, 5:00 am – 3:00 pm Saturday and Sunday, 6:00 am – 9:30 am. The early morning hours are intended to accommodate patients who are employed full time.

The applicant states that the long-term goal of the project is to "develop a comprehensive, innovative, holistic model of care for this patient population by bringing together the local academic and research resources of ETSU coupled with the medical care expertise and capital resources of MSHA (p. 7, initial application)."

ANALYSIS

A. NEED

1. A description of the geographic area to be served:

The proposed service area includes eight Tennessee counties corresponding to the TDMHSAS Planning Region I (Carter, Greene, Hancock, Johnson, Sullivan, Unicoi and Washington counties), three Virginia counties (Lee, Scott and Washington) and the locality of Bristol City, VA.

2. An analysis of the population of the area:

The applicant provides population estimates for each of the counties in the proposed service area, including 2016 estimates and projected 2020 estimates (including the Virginia localities). The total Tennessee service area estimates of 516,768 for 2016 and 538,738 for 2020 are generally consistent with estimates from the Center for Business and Economic Research (CBER), University of Tennessee, Knoxville (the

applicant's estimates for Carter County are 2% lower than the CBER in 2016 and 4% lower for 2020, which could result in a slight underestimate of need for that county).

3. The estimated number of persons in the described area who are addicted to heroin or other opioid drugs and an explanation of the basis of the estimate:

The applicant provides a chart compiling the data reported by the State Epidemiology Outcomes Workgroup (which includes the Department of Health, the TDMHSAS, Vanderbilt and East Tennessee State Universities, among others) showing significant increases beginning in 2011-2012 through 2014 in drug seizures, admissions to TDMHSAS substance abuse treatment services, crimes, arrests and drug poisonings associated with heroin abuse. The applicant also cites the estimated rate of adults addicted to opioid prescription drugs reported in "Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee" (created in part by the TDMHSAS) and applies that rate to the population counts from the proposed service area, resulting in an estimate of "29,000 individuals are in need of early intervention or treatment for addition to prescription opioids (p. 27)." In response to a request from the HSDA for clarification on the reference to early intervention, the applicant indicated that the larger proposed Center would provide early intervention strategies to a broader range of patients in addition to those receiving medical treatment through the OTP, and that the estimate of patient need for the OTP was based on an actual state patient count of patients being served by existing OTPs to the proposed service area (p. 5, Supplemental #1).

For that estimate the applicant cites a TDMHSAS 2012 report indicating that 9,221 Tennessee residents sought treatment at an OTP, which is a rate of 145 per 100,000 based on a state-wide population count of 6,361,070. This would be 932 patients for the entire proposed services area (TN and VA) for a 2016 population estimate of 643,005 and 950 patients for a 2020 population estimate of 655,045 (for the Tennessee area only, that would be 749 patients for 2016 and 781 for 2020).

The applicant goes on to suggest (pp. 41-42) that the rate of 145 per 100,000 may not adequately account for the rate of increase in indicators of heroin and prescription drug abuse and dependence, or for the likelihood that there are a number of people in the proposed service area who would be appropriate for OTP services who are not in treatment currently because of the distance to existing OTPs. The applicant suggests an estimate of 165 per 100,000 would be more accurate. Based on that rate, the applicant provides the following estimates of the potential patient pool and the proposed number of patients to be served in year one (2018) and year two (2019) of the program's operation:

	Total Patient Pool		Total Projected Patients	
	Yr. 1 2018	Yr. 2 2019	Yr. 1 2018	Yr. 2 2019
Tennessee	879	882	534	863
Virginia	191	191	116	187
Total	1,070	1,073	650	1,050

The TDMHSAS prevalence estimates show that, for the Region in which the service area is located, 4.6% of adults used non-medical pain relievers. Present percentages of adults using non-medical pain relievers in 2015 (using 2012 percentage of 4.6%) results in 18,522 for the service area. This does not represent the number of people needing treatment, only the number of people using opioids non-medically.

If 18,552 individuals report the non-medical use of pain relievers, an estimated 2,600 individuals or 14% would meet the criteria for substance abuse treatment based on estimates of the National Institute for Drug Abuse indicates on its website (www.drugabuse.gov/publications/research-reports/prescription-drugs/director). It is unknown what percentage of those 2,600 would be addicted to opiates and would be candidates for opioid substitution treatment such as methadone maintenance or buprenorphine-assisted treatment. As noted above, the applicant's estimate of total patient pool in the Tennessee counties based on a rate of 165 patients per 100,000 residents in year one of operation (2018) is 879 and in year 2 (2019) is 882. These appear to be reasonable estimates based on known rates of abuse and typical proportion of abusers appropriate for medication-assisted treatment.

4. **The estimated number of persons in the described area addicted to heroin or other opioid drugs presently under treatment in methadone or other treatment programs:**

The applicant notes that there currently is no methadone maintenance program in the proposed service area and reports utilization data from the three closest OTPs (two in Knoxville, one in Chattanooga). The utilization data was provided to the applicant upon request by the TDMHSAS and shows that 29 patients from the proposed service area are receiving treatment at the other OTPs. TDMHSAS-funded agencies reported 1,056 admissions in 2014 for the non-medical use of prescription opioids (1,019) or heroin (37) for the Tennessee counties in the proposed service area.

There is one approved CON for inpatient substance abuse services in the proposed service area. Strategic Behavioral Health has an approved CON for a 72-bed psychiatric and substance abuse facility which includes 10 beds for substance abuse detoxification services. This CON is not yet implemented and even when implemented it will not include methadone maintenance services.

5. **Projected rate of intake and factors controlling intake:**

The Applicant estimates an intake of as many as 60 patients per month during the first year, with factors controlling intake to include a mix of transfer patients currently in services and new patients (which require more time to admit).

6. **Comparison of estimated need to existing capacity:**

The applicant provides a chart of distance and drive times to the six nearest OTPs (including locations in Virginia, Kentucky and North Carolina as well as Knoxville, TN) to the proposed service area in direct comparison to the distance and drive times to the proposed location in Johnson City, TN to demonstrate how there is no existing capacity for methadone maintenance services for the proposed service area (pp. 34-35). The applicant acknowledges the presence of a number of buprenorphine providers in the area (estimated at 120, based on the Substance Abuse and Mental Health Services Association website) but reports that the intention of the proposed OTP is to meet the unmet need of

methadone substitution. The applicant estimates the need as just over 1,000 potential patients in the first year of operation with no existing capacity.

The applicant correctly notes that research indicates that methadone treatment has advantages over buprenorphine for patients with a high level of physical dependency while buprenorphine has advantages at moderate doses with less risk of overdose or abuse, and that the determination of which treatment is the best option must be made on a case-by-case basis. There is no empirical basis for estimating the proportion of patients better served by methadone replacement over buprenorphine. The applicant concludes that "(t)here is a role for both (methadone and buprenorphine) in the continuum of care for opioid addiction (Supplemental #1, p. 6)" and indicates that ESHHI intends to implement the availability of buprenorphine in year three of operation (2020) along with "broader elements of counseling, therapy, and recovery services (Supplemental #1, p. 10)."

B. ECONOMIC FEASIBILITY

1. Ownership and Management

Mountain States Health Alliance (MSHA) and East Tennessee State University (ETSU) have formed a not-for-profit corporation, East Tennessee Healthcare Holdings, Inc. (ETHHI) which will own and operate this proposed non-residential Opioid Treatment Program (OTP).

Mountain States Health Alliance is a tax-exempt entity with operations primarily located in Washington, Sullivan, Unicoi and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The primary operations of the Alliance consist of eleven acute and specialty care hospitals.

The applicant indicates that ETSU received approval from the Tennessee Board of Regents to create the Center for Prescription Drug Abuse Prevention and treatment envisioned to include an Administrative Core, a Patient Care Core, a Research and Evaluation Core and an Education and Outreach Core (p.13, initial application). The OTP is proposed to be one program in the Patient Care Core along with Neonatal Abstinence Prevention and counseling, recovery and support services provided through existing programs offered by Frontier Health Services, Inc. Counselors will be housed in the OTP facility and staff from the additional components will be housed in space adjacent to the clinic.

2. Expected Costs and Alternatives; Revenue and Expense Information

The proposed location is 203 Gray Commons Circle, Johnson City, TN in approximately 7,851 square feet of medical office space to be redesigned for an opioid treatment program. The site is owned by Mountain States Properties, Inc. and was previously leased to MSHA's medical management group for a family practice and urgent care. Use of this site would require local approval for re-zoning.

The site is approximately 1 mile west from exit 13 of 1-26 on TN-75 S. Bobby Hicks Highway/Suncrest Drive. The Gray Commons commercial development includes 38.8 acres of developable land (MSHA owns 36.2 acres and the City of Johnson City owns 2.6 acres). The estimate renovation cost of $1,747,777 is to be paid from MSHA cash reserves.

The floor plan enclosed with the application shows overall adequate space for the OTP and there are advantages to the site having previously been used as medical office space. However, it is not clear that the design allows for private dosing areas for each patient with a nurse who accesses the medicine in the pharmacy and can provide the dose directly to the patient without leaving the area. A common arrangement is for patients to enter a small private area from the lobby and address a nurse who is in the pharmacy area across a counter from the patient. This allows for a minimum of movement of the medicine while the nurse can directly observe the patient taking the medicine. Details of these or similar arrangements will need to be addressed during the development of the space.

The applicant does not intend to attempt to contract with TennCare during the first two years of operation in order to focus on initiating the operations of the clinic for self-pay clients and clients who quality for charity care (p. 2, Supplement #1). The applicant bases the proposal on operation without TennCare contracts, though options for contracting in the future for those clients whose methadone might be covered by TennCare (ages 18-20) or for buprenorphine prescriptions and enhanced support services beginning in year 3 of operations are discussed (p. 31 of initial application, pp. 2-4 Supplement #1).

Revenues for the OTP are calculated on serving 650 patients during the first year of operation (staggering the start date for the patients) and 1,050 patients during the second year. Deductions include some provision for charity care and expenses are primarily in salaries and wages. The applicant projects to operate at a loss in the first year of $326,421 with a positive bottom line of $956,425 the second year.

C. CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

1. Staffing and Treatment Information

The proposed staffing pattern shows adequate staffing of all clinical positions and strong staffing of medical coverage. A medical director will be half time the first year of operation and full time during the second year. There will be a full time on-site prescriber the first year and two full time positions the second year of operation. Nursing includes two full time RNs the first and second years with one full time LPN the first year and two the second year. The proposed pattern includes a full time program director of operations, therapists and indirect staff. The proposed staffing also includes a full time clinical pharmacist and a full time psychiatric nurse practitioner. The applicant provided target compensation for the staffing pattern which appears very competitive. There will be a total of 17 staff in place by the second full year of operation (p.8).

2. Effect on Existing Providers and Resources

The applicant notes that there are no methadone replacement providers in the proposed service area. The applicant provides a chart of distance and drive times to the six nearest OTPs (including locations in Virginia, Kentucky and North Carolina as well as Knoxville, TN) to the proposed service area in direct comparison to the distance and drive times to the proposed location in Johnson City, TN to demonstrate how there is no existing capacity for methadone maintenance services for the proposed service area (pp.

34-35). The applicant estimates the need as just over 1,000 potential patients in the first year of operation with no existing capacity.

The applicant acknowledges the presence of a number of buprenorphine providers in the area, estimated at 120, based on the Substance Abuse and Mental Health Services Association website. Physicians properly certified to prescribe buprenorphine have been limited to 30 patients the first year and then 100 patients, but a recent rule change by the Department of Health and Human Services (HHS), through the Substance Abuse and Mental Health Services Administration, would increase from 100 to 275 the number of patients that qualified physicians who prescribe buprenorphine for opioid use disorders can treat (change effective 8/8/2016 and includes additional requirements such as having been approved under a 100 patient limit for at least a year). Studies[1] conducted under the 100-patient limit found that 44%-66% of certified physicians actually prescribed buprenorphine, and the majority did not prescribe to their patient limit. The current proposal indicates the proposed OTP would provide only methadone during the first two years of operation with a primary objective to meet the unmet need of methadone substitution.

The agency Comprehensive Community Services in Johnson City, TN offers substance abuse services including adult outpatient and adult intensive outpatient services, residential services for adults and adolescents, but no methadone replacement services. The agency Families Free offers outpatient and intensive outpatient services for women including pregnant women, but again no methadone replacement services. As noted below (see 5.Working Relationship with Existing Health Care Providers), Frontier Health offers medically monitored withdrawal management in addition to a full range of substance abuse services. The proposed OTP program would not directly affect any of these existing providers and would add resources to the region.

3. Letters of Support

The applicant indicates that letters of support will be submitted directly to HSDA prior to the scheduled hearing (Supplemental #1, p. 20).

4. Implementation of State Health Plan

Healthy Lives: improving the health of people in Tennessee The proposed OTP is intended to provide methadone replacement treatment for people addicted to opioids, reducing the negative health effects of illicit use of prescription medicine and/or illicit drugs such as heroin, which often increases when access to prescription opioids is reduced through law enforcement and prescription monitoring procedures. Reduction in illicit opioid abuse also reduces associated health risks, such as disease associated with intravenous drug abuse. Methadone replacement treatment may be a temporary measure in an overall treatment course toward tapering medication assistance for a drug-free life, and is more likely to contribute to overall health when delivered in association with support services and additional clinical consultation available in the proposed Center for Prescription Drug Abuse and Treatment.

Access: improving access to health care and the conditions to achieve optimal health The proposed OTP is to be located in a region which does not currently have an

[1] Jones, C.M., Campopiano, M, Baldwin, G. & McCance-Katz, E. (2015) National and state treatment need and capacity for opioid agonist medication-assisted treatment. *American Journal of Public Health,* June 11, 2015.

OTP. The integration of the OTP with the Center for Prescription Drug Abuse and Treatment is intended to improve access to a range of drug abuse treatment and support services.

Economic Efficiencies: Health outcomes for patients of the proposed OTP are likely to be improved through integration with support services, prevention efforts, education, outreach, research and evaluation associated with the non-profit Center. This integrated approach is intended to improve economic efficiencies for OTP services above what a free-standing OTP could accomplish.

Quality of Care: the collaboration of Mountain States Health Alliance with the academic and professional expertise of the James H. Quillen College of Medicine at ETSU is a sound strategy to assure the quality of opioid abuse treatment services informed by the latest advancements in research and clinical care.

Workforce: The role of ETSU in the ETHHI project provides ample opportunity for the inclusion of trainees from a wide variety of health care professions in training on the prevention and treatment of substance abuse. Health care areas include medicine, pharmacy, nursing, counseling and social work. ETSU has established programs in the prevention and treatment of substance abuse. The applicant also notes that MHSA is already affiliated with the James H. Quillen College of Medicine at ETSU. This affiliation allows the staff of the proposed OTP to have access to the expertise of ETSU, supporting the maintenance of a well-trained opioid abuse treatment workforce.

5. Working Relationships with Existing Health Care Providers

   As noted above, the primary operations of the Mountain States Health Alliance includes 11 acute and specialty care hospitals in the region, and the Alliance is already affiliated with the James H. Quillen College of Medicine at ETSU. The proposed OTP would include a working relationship with Frontier Health (pp. 7-8, Supplemental #1), a community mental health agency with locations in East Tennessee and Southwest Virginia offering a wide range of mental health and substance abuse services. Frontier Health's existing substance abuse services include adolescent day treatment and outpatient services, adult outpatient, intensive outpatient and residential services, medical/social detoxification, medically monitored withdrawal management, women's intensive outpatient services, pregnant women's services and HIV/AIDS outreach. According to the proposal, Frontier began an opioid replacement program in Virginia in 2004 which includes induction, stabilization and reduction phases with a goal of medication free recovery. The applicant intends to contract with Frontier Health for 5.0 FTEs of counseling staff to be on-site of the OTP to facilitate referral to additional services (p. 8, Supplemental #1).

CONCLUSIONS

1. The need for a non-residential opioid-treatment program as part of a comprehensive approach to opioid abuse and dependence in the proposed region has been reasonably established. The applicant's estimates of opioid abuse and dependence in the identified region appear to be based on reasonable assumptions and accepted data (e.g. known rates of methadone maintenance usage in other parts of the state and indications in the proposed region of rates of opioid abuse and dependence). The applicant correctly cites

the difference between survey rates of "risky prescription of opioid use" and likely rates of need for OTP services (p. 5, Supplemental #1).

2. The proposed project appears to be economically feasible. Proposed staffing meets or exceeds licensure requirements and proposed salaries are consistent with market rates. Costs for program development and budgeting appear reasonable and documentation supports the availability of needed capital for start-up. The proposal allows for operating at a loss in the first year with a positive bottom line beginning the second year.
3. The application for a non-residential opioid treatment program as part of a non-profit corporation operating a center with a comprehensive approach to prevention and treatment of drug abuse would contribute to the orderly development of health care in the state of Tennessee. As proposed, the non-profit East Tennessee Health Holdings, Inc. would combine the established heath care delivery organization Mountain States Health Alliance with the academic and clinical expertise of East Tennessee State University, of which the OTP would be one service. The proposed partnership with Frontier Health, Inc. would establish an important relationship with an existing provider of comprehensive community mental health and substance abuse services and improve access to a range of substance abuse treatment to Tennesseans in this region struggling with opioid abuse and dependence.

Jeff Feix, Ph.D.
Director, Office of Forensic and Juvenile Court Services
Division of Planning, Research and Forensics
TDMHSAS

ADDENDUM
CERTIFICATE OF NEED REVIEW REPORT
CN1605-021 East Tennessee Healthcare Holding, Inc.

4. The proposed non-residential opioid treatment center would provide health care that meets appropriate quality standards. The applicant proposes to assure meeting appropriate quality standards by seeking licensure from the TDMHSAS and the U.S. Department of Justice Drug Enforcement Agency, accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF), and certification by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA: p. 56). The proposal's budget (p. 49) includes a line item of $10,000 in the second year of operation (FY 2019) to achieve accreditation by CARF which was designated in 2001 by SAMHSA as the accrediting agency for opioid treatment programs. The proposed organizational structure, physical plant, staffing and service delivery model are entirely consistent with current standards.

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